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Professionalism in Medicine and Medical Education, Volume II

Foundational Research and Key Writings

2010–2016

The articles appearing in this collection were originally published in *Academic Medicine*.

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Preface: Professionalism in Medicine and Medical Education, 2010–2016

I used to give lectures to residents about professionalism. I began with the various definitions of professionalism and moved on to describe conceptual models of professionalism and characteristics of professionals. After about 10 minutes of speaking, I would notice that one tired resident's eyelids were drifting down and then another and another until the room was half full of snoozing residents. I don't give those lectures anymore. Now I present real-life examples of residents' professionalism lapses. I have a long list from my years as associate dean of graduate medical education: the resident who wrote a prescription for a family member or colleague without any documentation of the doctor–patient relationship; the resident who had a sexual relationship with a patient; the resident who came to work hung over after drinking with friends the night

before; the resident who inappropriately looked at the chart of a celebrity who was in the hospital; the resident who used profanity and racial slurs when another resident refused to see his patient; the resident who posted a picture of a patient on Facebook. These true stories illustrate professionalism problems that can end a resident's career. No one closes their eyes when we talk about them. But professionalism is about more than the professionalism lapses that students, residents, and practicing physicians encounter during their careers. Just as we would not know much about water by describing a drought or thirst, we cannot develop a full concept of professionalism by only discussing professionalism failures. This e-book attempts to probe the nature of professionalism from multiple perspectives—scholarly, practical, and pedagogical—to help the

academic medical community better understand the current meaning of professionalism in our health system and how to educate our students and faculty about the current challenges associated with it. While professionalism has deep historical roots, the current health care environment is in a state of flux and presents new professional dilemmas that require continued study and discussion. I encourage our community to delve into the articles collected here from previous issues of *Academic Medicine* and to share them with colleagues, students, patients, and our community as we continue to develop the professional values that will guide us as the health system evolves.

David P. Sklar, MD

Editor's Note: The opinions expressed in this preface do not necessarily reflect the opinions of the AAMC or its members.

Academic Medicine and Medical Professionalism: A Legacy and a Portal Into an Evolving Field of Educational Scholarship

Frederic W. Hafferty, PhD

Abstract

In this Invited Commentary, the author examines two curated *Academic Medicine* volumes showcasing foundational research and key writings on professionalism in medicine and medical education, collectively spanning from 1994 to 2016. The author reviews the beginnings of the medical professionalism movement and examines how the trends and themes reflected in the first volume—specifically the work to define, assess, and institutionalize professionalism—capture key elements in this movement. He then examines how the trends and themes in the second volume align with and build on those from the first, noting two themes that extend across a number of second volume articles: a unit-of-analysis issue and the challenge of context. The author identifies several topics that have yet to be adequately mined and calls attention to two bridge-spanning articles in the second volume that, respectively, take us into the future (around the topic of identify formation) and back to the past (on the hidden curriculum). Finally, the author reflects on "directions home" in medicine's noble search for its moral core and collective identity.

This autumn, *Academic Medicine* releases the second volume in its series of e-books on medical professionalism. The first, *Professionalism in Medicine and Medical Education: Foundational Research and Key Writings 1994–2010 (PMME I)*, is a collection of perspectives, original articles, and research reports highlighting some of the most important topics and writings on the practice and pedagogy of professional preparation published in *Academic Medicine* from 1994 to 2010.[1] The second volume, *Professionalism in Medicine and Medical Education,*

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Volume II: Foundational Research and Key Writings, 2010–2016 (PMME II), continues in this tradition.[2]

Although the articles across these two volumes are arranged by date, there is no underlying intimation that they should be consumed serially. Nonetheless, the overall time period covered (1994–present), and the broad range of themes and issues included, captures, with remarkable fidelity, a good part of what we now refer to as "medicine's modern day professionalism movement."[3,4] This movement was preceded by an earlier (1970s) and quite vigorous debate within sociology about how large-scale social, economic, political, and technological change within U.S. society might be having substantial—and deleterious—effects on medicine's status as a profession and on the identity of physicians as professionals.[5–7] These sociological concerns and conclusions, although widely shared within the medical sociology community, had little discernible impact within organized medicine. Rather, as viewed by medical leaders, all was well within the House of Medicine. By the time medicine began to acknowledge these sociopolitical tremors and fault lines, the analytic fervor within sociology had ironically begun to abate.[8] This concomitant movement of awakening and abdication, however, did mark an important shift in the principal object of analytic concern—from sociology's long-standing focus on the *profession* as a collective entity to organized medicine's emergent preoccupation with issues of *professionalism*, particularly at the level of individual practitioners and trainees.[9] An iconic article in these respects is Arnold Relman's "The New Medical-Industrial Complex," published in the *New England Journal of Medicine* in 1980.[10] Relman's concerns with corporate threats to traditional medical practice were deliciously sociological in their framings, and very much about issues of profession and professionalism. Nonetheless, the article contains no direct references to sociology (including the aforementioned sociological debate), nor did Relman deploy either the term "professionalism" or "profession" in his analysis. A scant two years later, and in a similarly focused article published in *Health Affairs* ("The Future of Medical Practice"), Relman marshals sociological framings *and* the language of professionalism to warn colleagues about medicine's threatened status as a profession.[11] What intervened was the Pulitzer Prize–winning publication by Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*[12]—a book Relman[13] would admiringly review for his (as editor) journal.

PMME I is a testimony to the turmoil and excitement of this time. This volume accurately captures the array of concerns about how best to define, assess, and ultimately institutionalize

professionalism within the arenas of medical education and medical practice, and thus, it captures the movement as a whole. If nothing else (and this volume is a great deal more), *PMME I* is a portal into the collective thinking about professionalism of that era. While no one journal can claim to be *the* conceptual fulcrum of emergent medical thinking on professionalism, it also is true that there was a collective commitment within *Academic Medicine* to scholarship on this topic during the 1990s and early 2000s under the editorial stewardships of Addeane Caelleigh and Michael Whitcomb. When I wanted to bathe in cutting-edge work on medical professionalism during this time period, I turned to *Academic Medicine*—a choice I now find confirmed within PubMed and ISI Web of Science (as I conduct an informal search for indicators such as "most highly cited" professionalism articles—or just observe the sheer volume of work published on this topic during these two decades). These really were exciting times. Medical professionalism was a field of scholarship in search of its identity.

The portal into our historical journey opens to Volume I's first article on ethics training and the hidden curriculum.[14] In what today might be viewed as an existential disaster waiting to happen, much of medicine's formal efforts to define, assess, and institutionalize professionalism would generate a staggering array of unanticipated and unintended consequences; disjunctures in messaging arose between the "formal new" and the variety of informal, tacit, and indeed hidden ways in which medical trainees and practitioners traditionally had come to learn about what it meant to be a professional. In short order, and as a direct result of organized medicine's remedial frenzy, trainees found themselves enmeshed within learning environments in which formal curricula intersected in a variety of confounding and countervailing ways with other-than-formal curricula—generically labeled the "hidden curriculum" (but without everything being literally hidden or therefore negative). Students quickly found themselves betwixt and between as they began to wrestle with a bedeviling array of messaging about what it meant to be a good doctor. In turn, medical educators, ever so slowly, began to realize that creating definitions,

crafting assessment tools, and generating new curricula was a lot easier (and more productively seductive) than painstakingly effecting changes in the culture of medical practice.

Insightful windows into this bedlam of learning appear in *PMME I* under a variety of framings, including "hidden," "informal," "humanism," and "role modeling." For example, a heightened awareness of how role models functioned as important vehicles of tacit learning opened pedagogical eyes to the variety of messaging (both positive and negative) that these cultural standard bearers were in fact delivering. Likewise, the identification of professionalism by the Accreditation Council for Graduate Medical Education (ACGME) as one of its six core competencies set a bar not only for how residents should be taught and assessed regarding (among other things) their professionalism but also for how other types of providers, including faculty, might be assessed (even informally). Although not substantively reflected in this volume, concerns about issues of professionalism, humanism, and the hidden curriculum also raised parallel questions about the development and socialization of faculty.[15] In short, the development of formal definitions, assessment tools, and the variety of formal efforts to institutionalize professionalism (via the creation of codes, charters, competencies, and curricula) began to raise parallel questions about how this bubble of enthusiasm for professionalism might unintentionally contribute to a hardening of medical student hearts[16] and the vanquishing of their virtue.[17]

The excellence of these Volume I chapters notwithstanding (and every one has been seminal in shaping my own thinking on professionalism), there is a piece missing from our discussion: a "so what." So what if we define professionalism? So what if we teach and assess it? So what if we develop curricula and competencies regarding professionalism? How do we link what happens in medical schools to the more proximal and seminal issues of quality, outcomes, and patient safety? These questions deliver us to a linchpin article in the first collection, "Unprofessional Behavior in Medical School Is Associated With Subsequent Disciplinary Action by a State Medical Board," by Papadakis and colleagues.[18] By

empirically linking the unprofessional behavior of practitioners (via state medical board actions) with behaviors by students during their undergraduate medical training, we now had evidence of something long suspected: How students behave during medical school relates to how they might turn out as future physicians. From this point forward, not acting to address issues of professionalism within the halls of medical schools and clinical training sites could be viewed as not acting in the best interest of patients, and thus, not working to preserve the public's trust. As the opening decade of the 21st century drew to a close, all of these efforts at foundation building were beginning to support an emergent recognition as to "the complexities of" professionalism.[19–22]

Issues of context and complexity bring us to *PMME II*, which covers a shorter time frame but has no less thematic richness or contemporary relevance. Given Volume I's focus on issues of definition, assessment, and institutionalization, how does Volume II build on this infrastructure?

Quite well, actually. In fact, this volume provides 25 distinct and provocative quite-wells. Granularities aside, I want to highlight two themes that extend across most of the included articles. The first is a unit-of-analysis issue. The second targets the challenging issue of context. The unit-of-analysis theme seems a natural extension of the themes and topics covered in *PMME I*. As noted, much of the early work on professionalism focused its definitional, assessment, and institutionalization efforts on *individual* motives and behaviors. Social scientists, however, know that how a *community* defines or frames an issue (in this case, professionalism) exerts considerable influence on how members view what constitutes a legitimate response to those problems.[23] In short, definition shapes evaluation and resolution—or at least how the community is willing to approach analysis and what it is willing to consider as a resolution. If professionalism is defined as residing in the behaviors and motives of individual physicians and trainees, then solutions to that problem are similarly constrained. But, what if the problem is not one of motives? What if the answers to issues of professionalism are not to be found (exclusively) in more course work, more

frequent assessment, or more strictly enforced codes? What if the issue is not so much individual people but, rather, *context*, the settings in which they operate? As we move into *PMME II*, we encounter a broad array of efforts to wrestle more aggressively with both this unit-of-analysis issue and with that of context.

Issues of context appear in a variety of places and manifestations across Volume II—particularly within the orienting framework of culture. A recognition that "our" (and yes, there is intentional irony here) understandings of professionalism have a decidedly Western and Eurocentric underpinning make an important appearance—both as a general critique and with specific references to alternative framings (e.g., Japan; Taiwan). Here too, we explore differences between how medical schools define and remediate professionalism in the United States and how they do so in Canada. Volume II also begins to delve into issues of race/ethnicity through a professionalism lens. These multinational, cross-national, and racial/ethnic broadenings also push us to imagine what is missing and how potential future volumes might showcase perspectives from the Middle East, South America, and Africa.

Volume II also begins to move us toward a more aspirational framing of professionalism and away from a rules-based and command-and-control approach. In addition, writings on the hidden curriculum become more granular and contextual, including more explicit efforts to link this conceptual tool to topics such as professionalism and, as a somewhat separate issue, humanism.

Notable in this volume is the connection of professionalism to a variety of important themes in medical education and medical practice such as the techniques of appreciative inquiry and reflective ability, along with the concept of emotional intelligence. Evoking Robert K. Merton's sociological framing of unintended consequences,[24] we also begin to encounter a more refined recognition that what we intend (be it with curricula, assessment, or codification) is not necessarily what we reap. From a student perspective, we witness how explicit efforts to inculcate professionalism in one formal teaching setting (anatomy) can easily be

undercut or negated when subsequent educational venues either teach alternative framings or, worse yet, ignore issues of professionalism altogether (and thus convey "important" messages about professionalism via the null curriculum).[25] Meanwhile, the somewhat marginalized "magic bullets" (to use the sociologist Renee Fox's framing[26]) of medical ethics and the humanities are given a fresh reexamination via the lens of professionalism. Here too, newer topics are accorded their moment in the professionalism sun, including issues of wellness, work–life balance/integration, burnout, and social media. These topics, while expanding our understanding of the contextual dimensions of professionalism, also, for the most part, reinforce an individual rather than a collective framing of professionalism issues.

It also is worth mentioning what we do not see, if only as a beacon for potential future volumes. While definitional and assessment issues have a much lower profile in Volume II, when they do appear, it is with important reframings. For example, Wynia and colleagues' contribution[27] deliberately highlights professionalism as a collective enterprise and thus seeks to shift the definitional conversation away from its more traditional and individualistic roots. Alternatively, issues of assessment are noticeable in their absence and thus appear enigmatic. Perhaps *Academic Medicine* needs to more aggressively move toward extending the boundaries of contemporary professionalism assessment[28–32] and thus push the community beyond those earlier and groundbreaking works by scholars such as Louise Arnold,[33] David Stern,[34] and Shiphra Ginsburg and colleagues?[35] Perhaps we need to explore the interplay of formative versus summative assessment in the context of professional formation? We also need a more empirical work on organizational professionalism, not only in terms of how organizational context comes to shape the presence and practice of professionalism at the individual level but also in terms of how organizations themselves can meaningfully be viewed and assessed as professional entities in their own right.[36] This means, among many other concerns, thinking about organizations as something other than a collection of individuals whom we happen to consider

"professionals." And per our discussion above, organizational context is also a unit-of-analysis issue.

We should extend this call for more empirical and conceptual attention not only to assessment but also to issues of diversity and inclusion, interprofessional education, maintenance of certification, and further global framings (including whether we should be moving to a singular global idea of "professionalism" or to more contextually/regionally based understandings).

Also yet-to-be adequately mined are the more clinical issues of patient safety and quality of care. Definitional framings of professionalism in places such as the United Kingdom are much more inclusive in these respects than what we encounter in the United States, perhaps influenced by the ACGME's identification of professionalism as a distinct competency.

Also lacking is how we better understand professionalism from within the politics of inclusion and exclusion. The issue of race-conscious professionalism highlighted in this volume needs to be extended to the related issues of ethnicity, gender, social class, sexual identity, disability, and religion, among others. For example, the exploration of how formal and other-than-formal educational practices within medicine and medical education produce heteronormativity, although quite visible in scholarship outside of medicine,[37,38] has yet to make an appearance within the medical education literature. Issues of marginality also bring us back to the hidden curriculum, since the composition of our training milieus—which includes our provider and patient populations—have an important impact on how we conceptualize what it means to be a professional.

This—the idea of what it means to be a professional—brings me to the topic of professional identity formation, a hot topic of late, and one that purposefully has been excluded from this volume with the possibility that it will receive its own focused treatment at a later date. Still, how identity, as a conceptual lens, furthers conversations about professionalism, and does so at both the level of individuals and organizations, remains an important challenge to issues of professionalism. Meanwhile (not to

connect professionalism to every hot topic), other concerns, implicit bias being one, need to be aggressively explored through a professionalism lens.

Before ending, I want to direct special attention to the two concluding articles in *PMME II*. Both are bridge spanning in that they take us into the future (around the topic of identify formation) and back to the past via the opening article of *PMME I* (on the hidden curriculum[14]). In these respects, the articles by Irby and Hamstra[39] and by Jha and colleagues[40] function as lenses through which we can examine the rich legacy of themes and articles that appear across these two volumes. By differentiating among virtues, behaviors, and identity, Irby and Hamstra cover the waterfront of definitional, assessment, and institutionalization practices, while also providing us with a stepping-stone to an emerging (identity formation) literature. In turn, the use by Jha and colleagues of a planned behavior to fitness (PBF) approach to professionalism asks us to revisit a number of what will be familiar themes within the two volumes: behavior versus identity, remediation, and what the authors characterize as their desire to examine the more "hidden dimensions of professionalism," including context, social norms, interpersonal relations, and local cultures. The authors' focus on relationships is of particular interest to me because it points to the potentially exciting ways in which we might explore professionalism from a relational perspective,[41–43] be that relationships among individuals, among organizations, or among the complex array of ways we have begun to think about professionalism.

Endings should contain some mixture of optimistic and cautionary flavorings. Not to belay the obvious, but however unique their execution, *PMME I* and *PMME II* represent a singular, albeit important, portal into the evolution of medicine's modern-day professionalism movement. Over the years, a number of medical journals, educationally focused and otherwise, have marqueed critically important work in this evolving field. Nonetheless, as I look across this extended waterfront of publications, I am left with a disquieting sense of unease. In something akin to a phrasing ("no direction home") made famous by this year's Nobel Prize–winning liturgist, Bob Dylan, I

harbor reservations as to where this whole "professionalism thing" is going. In spite of the vast literature that has been generated, professionalism continues to occupy an enigmatic presence within the medical community. It has an underdeveloped presence in maintenance of certification and continuing professional development frameworks. Similarly, the Liaison Committee on Medical Education has embedded relatively few specifics about professionalism in its compendium of standards. Professionalism does have a higher profile within the ACGME's milestones project and in its Clinical Learning Environment Review initiative[44,45]—although both projects are evolving and remain relatively separate undertakings. Perhaps even after two decades of conceptual and empirical excitement, now is too soon to expect inklings of closure?

But perhaps this desire for closure is its own no direction home. Perhaps professionalism is more of a journey than a destination. Perhaps professionalism is best captured not in a definition or metric but in the willingness of a community to engage with itself in an ongoing and reflective search for a soul defined by the core values of selflessness and service? Perhaps the true promise of medical professionalism lies not in professional dominance or in the metrics of accountability[46] but in the willingness of a community to do its best, patient by patient, and to do so even in the face of the increasing social divisiveness that today seems to dominate so many specters of social life? Perhaps the true promise of professionalism lies in medicine's collective ability to function as a beacon of hope where the relentless pounding of market and bureaucratic forces are continuously and conscientiously opposed by another, socially vital way—of organizing work and valuing agency.

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What Students Learn About Professionalism From Faculty Stories: An "Appreciative Inquiry" Approach

Jennifer L. Quaintance, PhD, Louise Arnold, PhD, and George S. Thompson, MD

Abstract

Purpose

To develop a method for teaching professionalism by enabling students and faculty members to share positive examples of professionalism in a comfortable environment that reflects the authentic experiences of physicians. Medical educators struggle with the teaching of professionalism. Professionalism definitions can guide what they teach, but they must also consider how they teach it, and constructs such as explicit role modeling, situated learning, and appreciative inquiry provide appropriate models.

Method

The project consisted of students interviewing faculty members about their experiences with professionalism and then reflecting on and writing about the teachers' stories. In 2004, 62 students interviewed 33 faculty members, and 193 students observed the interviews. Using a project Web site, 36 students wrote 132 narratives based on the faculty's stories, and each student offered his or her reflections on one narrative. The authors analyzed the content of the narratives and reflections via an iterative process of independent coding and discussion to resolve disagreements.

Results

Results showed that the narratives were rich and generally positive; they illustrated a broad range of the principles contained in many definitions of professionalism: humanism, accountability, altruism, and excellence. The students' reflections demonstrated awareness of the same major principles of professionalism that the faculty conveyed. The reflections served to spark new ideas about professionalism, reinforce the values of professionalism, deepen students' relationships with the faculty, and heighten students' commitment to behaving professionally.

Conclusions

Narrative storytelling, as a variant of appreciative inquiry, seems to be effective in deepening students' understanding and appreciation of professionalism.

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The topic of professionalism in medicine continues to garner the attention of the medical education community, and medical educators struggle with teaching professionalism. To teach it, medical educators need to be clear about what professionalism entails. There has been considerable discussion about the definition of professionalism, and many organizations and individuals have presented their understanding of medical professionalism.[1–3] At the core, these various perspectives are quite similar. The definitions emphasize key principles and behaviors such as humanism, accountability, altruism, and excellence and may include clinical competence, ethical and legal understanding, and communication skills. These definitions can guide what we teach about medical professionalism, but we must also consider how we teach professionalism so that students can internalize what we teach them. Constructs such as explicit role modeling, situated learning, and appreciative inquiry can shed light on how to teach professionalism.

Medical educators have suggested that role modeling is the method most frequently used to teach about professionalism, but they agree that role modeling alone is not sufficient for inculcating professional attitudes and values in medical students.[4–8] Rather, students need faculty members to be more purposeful and explicit in their teaching and modeling of professionalism.[4] Effective physician role models enable learners to internalize the principles of professionalism so that learners themselves act professionally.[6] These physician role models practice what they preach by regularly demonstrating professionalism and then preach what they practice by providing compelling, explicit justification for their actions.[6] They productively and sensitively discuss their own strivings toward professionalism and their own shortcomings while teaching students.[6] They are not silent models.

The widely used educational theory, situated learning, offers guidance on how to more effectively use role models and mentors to transmit professional attitudes and behaviors. Situated learning theory recognizes the importance of the learning that occurs as a result of the interactions among learners, their environment, and other participants, such as role models within the environment.[8] Particularly important to the learning process is talk; learners come to a deeper understanding of their role in the environment through "talking about" and "listening to talk" about key elements of the physician's role.[8] Advocates of situated learning contend that learning is

most effective when there is a balance between explicit teaching (listening to talk) and active participation in (talking about) authentic, "real-world" activities. Situated learning emphasizes the role of authentic activities in helping learners apply abstract concepts in useful ways, which will lead to greater internalization of the concepts.[4,6,8,9] The internalization of these concepts can be enhanced even further by encouraging learners to engage in active reflection and through their witnessing role models who are engaged in active reflection.[9,10] Physician educators are in a unique position to teach students about the attitudes and behaviors of professionalism by encouraging students to listen to talk during formal didactic sessions, informal conversations, or role modeling during patient interactions and also by encouraging students to talk about their own experiences, triumphs, and struggles with professionalism.

Although role models can have an important and positive influence on students' development of professionalism, the influence of negative role models is pervasive and can be destructive.[4,6,11–13] It is appropriate, then, that much of the literature on medical professionalism focuses on the lapses of faculty, residents, and students. This focus is valuable because it begins to elucidate students' and physicians' perspectives on lapses in professionalism and potential causes of the lapses.[14–16]

It is equally valuable to consider the professional behaviors and attitudes toward which faculty and students should strive and the methods by which those behaviors and attitudes are conveyed to students. In this respect, appreciative inquiry methodology can provide unique guidance. It proposes that lasting organizational change occurs as a result of focusing on where the organization is headed rather than focusing on where the organization has faltered.[17] Appreciative inquiry also encourages the development of a "vocabulary of hope" to dramatically move the focus from the negative toward the positive.[18] Medical educators at the Indiana University School of Medicine have made important strides toward successfully implementing appreciative inquiry strategies and have seen meaningful and considerable changes in the culture of professionalism at their institution.[19,20]

Thus, to internalize professionalism, students need (1) to receive explicit teaching about behaviors and values of professionalism within authentic contexts, (2) to witness as their role models reflect on their own understanding of and experiences with professionalism, (3) to reflect on their own experiences, and (4) to focus on and be exposed to positive instances of professionalism. The question then becomes: How can medical educators with limited time and resources accomplish all of these tasks in such a way that students will receive and internalize the intended messages about the formal values of professionalism?

Drawing from the literature on teaching professionalism, we implemented a project to enable students and faculty to talk about positive examples of professionalism in a comfortable environment. The purpose of this report is to describe the project, which consisted of conversations between students and faculty on the topic of professionalism and the students' reflections about those conversations. This report will answer three questions: (1) What are the components of the project? (2) How was it implemented? (3) What did the students take away from the conversations they had with faculty members?

Method

Rationale and purpose of the project

Faculty requests for assistance in improving their teaching of professionalism prompted this project. After reviewing the literature on the teaching of professionalism, we decided to use situated learning theory and the appreciative inquiry method to guide the development of the project. Situated learning theory indicates that a balance between explicit teaching and participation in authentic, real-world activities is important. We also knew, from the negative perceptions of lectures on professionalism that students expressed in their course evaluations, that the influence of formal didactic sessions would be minimal. We needed to create an environment within which students and faculty could have conversations about professionalism that would allow for explicit teaching in an engaging and authentic context. Furthermore, we found inspiration from the efforts at the

Indiana University School of Medicine and decided to apply the appreciative inquiry method at our institution. Thus, the purpose of the project was to increase medical students' awareness and appreciation of the principles of professionalism and to provide contexts within which faculty members and students could discuss professionalism.

Components of the project and its implementation

With approval from our institution's institutional review board, we implemented the project in 2004 at the University of Missouri–Kansas City School of Medicine, a public school with a six-year combined baccalaureate degree/MD program. Throughout the entire program, students are part of learning communities led by physicians, who in this role are called docents. In their first year, students are placed in 12-member learning communities, where they shadow one docent twice a week for two years (year 1–2 communities). In their third year, students join a learning community consisting of approximately 12 students drawn equally from years 3, 4, 5, and 6 of the program (year 3–6 communities). In year 3, students attend a weekly continuing care clinic with their year 3–6 communities. In years 4 to 6, students continue to attend the weekly clinic and also participate, for two months of each year, in internal medicine care of inpatients with their year 3–6 communities.

The docents, who are internists, formally serve as role models, advisors, and instructors for the student members of the learning community. Students consistently report in the Association of American Medical Colleges' Graduation Questionnaire and in program evaluation studies[21] that their docents are very influential role models.

At the request of two of us (L.A. and G.S.T.), the chair of the Department of Medicine strongly encouraged docents to incorporate the project into the ongoing educational activities for their learning community. In addition, L.A. and G.S.T. recruited one to three student volunteers within each learning community to carry out the interviews. The individual learning communities scheduled the interviews so that as many members as possible could attend. No incentives for participation were offered to either

docents or students. The project consisted of two components: students' interviews of their docents and students' reflections on and writing about the stories their docents told.

Interviews. One of us (G.S.T.) trained 84 students and 36 docents to participate in the interviews. Training for students (90 minutes) and docents (15 minutes) allowed them to become familiar with the interview guide, which emphasized that the interview was designed to elicit positive examples of professionalism and that the participants should avoid sharing negative examples. Student training included substantial role-playing so that the students could become comfortable in their role as interviewer.

The interviews typically occurred in a small-group setting, either before or after a learning community's clinical teaching session, and they lasted between 30 minutes and an hour. One to three students asked questions of their docent, and the remaining 9 to 11 students observed the interview. Most of the interviews involved year 3–6 learning communities, although several of the year 1–2 learning communities also conducted interviews of their docents. A total of 62 students interviewed 33 docents, and 193 additional students observed the interviews.

The interviews were semistructured. The interview guide consisted of nine topic areas suggested by the following requests:

• Tell us about a time when you or another physician went the extra mile to help a patient.

• Tell us about a time when you or another physician acted with respect, empathy, or compassion for a patient.

• Tell us about a time [when you witnessed] a physician who followed the highest standards of behavior and refused to violate his/her personal and/or professional code.

• Tell us about a time [when you witnessed] a physician who fulfilled his/her responsibilities and obligations.

• [Tell us about] a time when you felt you were really learning something new, meaningful, and helpful to the health of your patients or your community.

• Describe a physician who seems to [carry] his/her responsibilities to patients easily and to freely commit to serving patients or others without feeling burdened.

• Tell us the story of what inspired you to start thinking about becoming a doctor.

• Tell us a story about a time when you felt most involved in, most excited about, or most satisfied with your practice of medicine.

• Tell us a story about some things you value deeply—specifically, things you value about (1) yourself, (2) the nature of your work, and (3) the medical profession.

We instructed students and docents to discuss at least three of these areas; most of the interviews addressed all nine requests.

Writing. We invited the student interviewers and observers to share the narratives they heard by posting them to a project Web site. The directions for posting were as follows:

> Please recount the narratives shared during your interview for each of the questions discussed. If the question was not asked or discussed, leave the response box blank. At a minimum, recount the best story told for each question. You also have an opportunity to recount other shared stories if you wish. Again, if no other stories were shared or [if] you do not choose to recount additional stories, leave the response box blank. You only need to recount the story, as close to verbatim as possible; you do not need to report here any discussion that resulted from telling the story.

We also asked the students to reflect on a narrative that was particularly meaningful for them by responding to these two requests: (1) "Please tell us what this story taught you about being professional," and (2) "Please describe how you imagine that [your approach to] your work . . . [or attitude toward professionalism] may change as a result of hearing and learning from this story."

Thirty-six students wrote a total of 132 narratives (ranging in length from 37 to 1,095 words). Each student offered his or her reflections on one narrative of his or her choice. Reflections ranged in length from 10 to 386 words. We asked the docents to check the students' narratives for accuracy. None of the docents took issue with any of the narratives.

Data analysis

We analyzed the content of all of the narratives and reflections. Two of us (J.Q. and L.A.) developed the coding scheme for the narratives through an iterative process involving periods of independent coding and discussion to resolve disagreements. Open coding of a random sample of approximately 20 narratives indicated that the data closely matched existing definitions of professionalism. We selected the definition of professionalism proposed by Arnold and Stern[1] to guide the data analysis because that definition is succinct and yet comprehensive in covering principles included in other definitions of professionalism. We used the definition to craft criteria for inclusion and exclusion and to arrive at a final coding scheme to use in the analysis of the 132 narratives. To provide validity evidence, we trained a third researcher, who was not previously involved in the project, to use the coding scheme. Then we independently coded a random sample of 26 narratives (20% of the total). We resolved the few disagreements between the initial and subsequent coding through discussion.

To identify the principles of professionalism identified in the reflections, we took the same analytic approach as we used for the narratives. Two of us (J.Q. and L.A.) also used standard open-coding techniques to discover the students' depth of awareness about professionalism principles, the ways that students derived meaning from the narratives, and the ways that the process supported the development of their knowledge of, attitudes about, and skills in professionalism. After reading a random sample of 20 reflections and independently generating initial impressions, we collaborated in creating an open-coding scheme. We refined the initial scheme through paragraph-by-paragraph comparison and negotiation and then verified the scheme by analyzing the remaining reflections. As we did for the analysis of the narratives, we added a third investigator (G.S.T.), who was not involved in developing the initial coding scheme for the reflections, to validate the coding scheme by independently coding a random sample of 20% of the reflections. There were no disagreements between the coders.

Results

Narratives

According to the students' narratives, docents told stories about the principles of professionalism—humanism, accountability, altruism, and excellence. The number of subthemes found in the narratives matched the richness and complexity that characterize many definitions of professionalism.[1–3]

Humanism. Docents' stories embedded humanism in relationships: "Dr. X provided years of routine care that culminated in his being present for the patient and his wife when the patient died." Many stories were about caring, compassion, kindness, and empathy, all subthemes of humanism. A neurosurgeon, for example, was particularly attentive to the emotional needs of a family who had lost their father: "His kindness disproved the stereotype of surgeons' behavior." Other stories were about respect for others and frequently highlighted caring for the whole patient as an example of respect. Honesty, integrity, and humility were also described as being vital to humanism: "You always know exactly where you stand with her; there are no hidden agendas or secondary motives."

Accountability. Docents' stories described accountability as the passing of knowledge and skill to the next generation, as well as service to the community and general public. Another frequently mentioned theme was advocacy for patients:

> After the patient [a sex offender] had been hospitalized for several weeks, I was pressured to discharge him . . . to a halfway house. I continued to look for another option. . . . I kept him in the hospital until I found an [appropriate] facility that agreed to take him.

A different docent's story also told about free acceptance of duty:

> On a flight, over the intercom came a plea for physicians to assist a passenger in pain. I didn't feel an obligation to work, since I wasn't on call or in the hospital. But guilt crept over [me], and I got up. At the end of the flight, the flight attendant gave me a sock puppet. I keep it on my table as a reminder of my duty as a healer.

Altruism. Docents' stories depicted altruism primarily as self-sacrifice—expending extraordinary time or effort in patient care; seeing patients at home, in shelters, or in nursing homes; and caring for patients in the face of risks to oneself. For example, "There was no one else to donate blood to this little African boy. My docent and the boy had the same blood type, so she donated her own blood to him." Putting patients first and caring for patients in crisis situations were other subthemes of altruism. The stories also recognized the critical importance of altruism in patient care: "A doctor's poise and altruistic manner determine whether or not he will receive poor information, [which could lead] to a poor diagnosis, poor treatment, and possibly lawsuits."

Excellence. Docents' stories framed excellence as involving lifelong learning, as being an important way to avoid stagnation, and as recognizing and admitting mistakes: "A person is only as good a doctor as [his or her] most recent mistake." The narratives expressed admiration of physicians who conducted research, published, and moved medical knowledge forward and of those whose curiosity, thoroughness, effort, and persistence led to quality patient care. One docent said, "My associate believed the patient's arm could be saved from amputation if a special orthotic could be designed . . . and he [saw to it that this was done]." Often, the narratives recognized outstanding expertise and a striving to do more than the minimum, so as to meet exceptional standards, as aspects of excellence. Some of the narratives included reports of extraordinary behavior that demonstrated caring and compassion, rather than technical brilliance or persistence, as a part of excellence:

> Dr. Y went the extra mile for all his patients. He knew [that] patients can get shuffled around between different clinics. [So] he cared for his patients in all of the ways that he could; for example, he would clip the toenails of patients who had mobility restrictions and couldn't do it themselves, even though he could have simply sent them to a podiatrist.

Conflicts between principles. Sometimes the narratives explored conflicts between different principles of professionalism. In the quotation, a docent provides an example of a conflict between humanism and accountability to an institutional policy on pets:

> A homeless man arrived with his dog. Dr. T decided [that the man] needed to be admitted, but he refused because he didn't want to leave his dog alone. . . . Dr. T offered to take care of the dog, who spent the rest of the shift in the employees' lounge, and a nurse took the dog home with her.

Some narratives also described conflicts between the principles of professionalism and personal life:

> When the docent's wife was pregnant with their second child, [the docent] tried his best to be considerate of the other faculty. He [arranged to take] time off around his wife's due date so he could be at home with her and [could] care for their new baby. He was conscious of the fact that, if he did not come to work . . . or [if he] left suddenly in the midst of the day, he would leave another docent . . . with a double load. . . . However, the baby decided to come a week early. . . . He dutifully reported to work the morning after his wife's delivery. . . . As he was sitting in the outpatient clinic . . . another docent insisted that he leave and would not take "no" for an answer.

Narratives about this type of conflict either described the resolution of the conflict or left the conflict unresolved.

Reflections

In their reflections, students demonstrated awareness of the same major principles of professionalism that the docents conveyed in their stories. For example, one docent talked about the early days of treating patients who were HIV-positive and related how much he appreciated the physicians who accepted their duty and put their fears of infection aside. The student wrote the following reflection identifying the concept of free acceptance of duty:

> The story regarding setting high standards was particularly touching, in that it made me realize my purpose as a health care professional. There are times when I forget that being a physician is a label of privilege. As such, it is my duty to set aside my fears and help those who seek my skills as a physician. This story helped rekindle those aspects of this profession and helped me realize my duties.

The depth of awareness of the principles of professionalism that students demonstrated ranged from superficial to deep. A particularly deep reflection read, in part,

> As future physicians, we must remember that we are individuals, born out of the same flesh and blood as our patients and endowed with the same vices and virtues

as those we treat. We do not belong to some elitist, esoteric club, but, rather, we all belong to the same fraternity—that of humankind. Having spent the majority of my life exposed to the field of medicine, this is something that I have realized is often easy to forget. We must remember that at the very core of professionalism lie respect, humility, and honesty. Yes, ambition is good, but only when it is tempered by compassion. This is what distinguishes medicine from the free-market world in which we live.

An example of a surface-level reflection read,

> [The docent's narrative] taught us the importance of acting professionally and [about] how all of your actions affect the patients and how they feel about themselves. Our attitudes and approaches to work will change because we will think about putting our patients' needs first and always treating them with respect and dignity.

A few students, mostly in the first year, missed the point of the faculty members' stories. For example, after hearing a faculty member talk about how his interest in psychology led him to choose psychiatry as a career because he felt he'd be able to do more good as a psychiatrist than as a psychologist, the student did not frame the reflection in terms of professionalism but saw the story as justification of pursuing one's self-interest:

> This story has taught me that being a professional doesn't mean giving up on things that you like. Instead, it means taking your interests and developing them even further. Oftentimes I have gotten so caught up in what I am interested in that I don't see many of the possibilities that can result from my interest. . . . I think, after hearing this story, that I will be more willing to pursue my personal interests in the medical field rather than separating the two.

Students gave personal meaning to the narratives by applying the principles of professionalism to new contexts, empathizing with characters in the narratives, and exploring connections among professionalism principles. For example, one student likened the poor patient care characteristic of the beginning of the AIDS epidemic to the poor patient care often offered today to patients without health insurance. In response to a story about a group of residents who purchased baby clothes for a new, low-income teenage mother,

another student noted, "[This story] taught that professionalism includes truly seeing the patients as people and learning about the lives they come from, and, by [doing] this, you can effectively treat their symptoms."

The narratives served to develop students' knowledge, attitudes, and skills about professionalism in numerous ways.

1. They sparked new ideas about professionalism:

   > I have always attempted to separate my emotions from the practice of medicine, especially when I feel [that] people [will] look at me as if I am overemotional. I feel now [that] I will find the happy balance between the two, as families and patients are okay with emotions.

2. They reinforced previously held conceptions of professionalism:

   > The constant verbal badgering about how you need to remain professional in all of your doctor–patient relationships truly sinks in when you get it from someone you look up to and respect.

3. They suggested ways to resolve future professionalism conflicts:

   > I would imagine that I will carefully watch the way I treat patients and friends. Sometimes, you treat others in a cold manner without even knowing it. So this story teaches me that I need to try my hardest to make the patient feel as though we are there to help them.

4. They heightened students' commitment to professionalism:

   > Our work will change as a result of hearing these stories. We have more respect for our docent doctor, and also we try to learn from his behavior and achieve the highest satisfaction from our patients and peers. That means we have to give everything we have, listen to our own hearts, and have our actions mirror the best interest of [our] patients, others, [our] community, and ourselves alike.

5. They offered inspiration:

   > What he said was very inspirational, and I would like to think of him as a role model and a mentor, one [whom] I would like to model myself after.

6. They provided enjoyment:

   > I really enjoyed the story of how the residents were able to pull together and help pay for a patient's medication.

7. Finally, the reflections revealed that the process of listening to and reflecting on

the docents' stories deepened students' relationships with docents:

> This story was important to me because it makes me see the doctors that I am surrounded by every day . . . more [as] people. . . . It was reassuring to me to hear that my doctors, who seem to know everything, felt just as inadequate as I do now.

Discussion

Analysis of the data revealed that the physicians' stories contained the same principles included in most definitions of medical professionalism.[1–3] The narratives were stories about physicians who acted with honesty, respect, and compassion—that is, humanism; physicians who freely accepted their duty to help others and who advocated for patients who could not advocate for themselves—that is, accountability; physicians who sacrificed their time and sometimes even their personal safety in the interest of serving patients—that is, altruism; and physicians who strove to exceed expectations and who persisted until patients received the best possible care available—that is, excellence.

By far, of all of the principles of professionalism, the one the narratives most often talked about was humanism, which was typically described in terms of "going the extra mile" or exceeding expectations with regard to caring, compassion, and respect. Accountability was the next-most-often-addressed principle of professionalism; however, it lags far behind humanism in terms of the frequency of mention and the number of its subthemes. The narratives held physicians accountable to their patients, their colleagues, their students, and society at large. Altruism was the third-most-frequently cited principle in the narratives, where it was depicted as self-sacrifice and as putting patients' interests above physicians' interests. Finally, excellence was the principle cited least often in the narratives, and its mention typically involved a reference to lifelong learning.

Students' reflections on the narratives indicated that they learned from and valued the docents' stories. Students were able to identify and, more importantly, seemed to internalize many of the concepts embedded in the docents' stories. For example, they empathized

with the patients, families, doctors, and other health care workers in the stories and routinely applied the concepts in the narratives to different contexts or to their own experiences. Some students were also able to articulate the relationships between key principles of professionalism. The narratives helped students to develop knowledge, attitudes, and skills related to professionalism by sparking new ideas, reinforcing older notions, and heightening a commitment to act professionally. A few students indicated that they felt they had been changed by the experience and said they would try to reflect their new attitude toward professionalism in their daily work with patients.

The conversations between physician role models and their students provided an opportunity for faculty members to be explicit[4–8] about their professional values and to do so in an engaging manner. Furthermore, the students' reflections indicated that they understood the messages the faculty members were trying to impart. The stories that the docents told were almost exclusively set within their own authentic, clinically oriented experiences as physicians in training or physicians in practice in the community and on the medical school faculty. The conversations provided students with the opportunity to "listen to talk" about important concepts of professionalism.[8] In addition, during many of the interviews, students and faculty had brief discussions, which allowed students an opportunity for "talking about" the issues embedded in the stories.[8] Finally, the active reflection that students both witnessed from their docents and engaged in themselves was an important component of the project.[9,10]

The conversations have begun to build, in Ludema's phrase, a "vocabulary of hope."[18] The physicians had a great number of stories about professionalism to share with their students, and, with few exceptions, the stories were positive. Stories about simple acts, such as buying a patient a milkshake, or extraordinary acts, such as putting one's life in danger to rescue people from a collapsed building, can provide students with a sense of hope that acting professionally is one of the most rewarding aspects of medical practice. In turn, the students were often moved by these positive examples of professionalism, a response that led to feelings of inspiration and a renewed commitment to professionalism. Finally, this process helped to deepen students' relationships with faculty members and perhaps reinforced their importance as role models.

Conclusions

On the basis of our analysis of the narratives and reflections, we believe that the students learned a great deal about professionalism. Narrative storytelling, as a variant of appreciative inquiry and situated learning, seems to be an effective way for students to deepen their understanding and appreciation of professionalism.

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Medical Students' Professionalism Narratives: A Window on the Informal and Hidden Curriculum

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Abstract

Purpose

The aim of this study was to use medical students' critical incident narratives to deepen understanding of the informal and hidden curricula.

Method

The authors conducted a thematic analysis of 272 stories of events recorded by 135 third-year medical students that "taught them something about professionalism and professional values." Students wrote these narratives in a "professionalism journal" during their internal medicine clerkships at Indiana University School of Medicine, June through November 2007.

Results

The majority of students' recorded experiences involved witnessing positive embodiment of professional values, rather than breaches. Attending physicians and residents were the central figures in the incidents. Analyses revealed two main thematic categories. The first focused on medical–clinical interactions, especially on persons who were role models interacting with patients, families, coworkers, and colleagues. The second focused on events in the teaching-and-learning environment, particularly on students' experiences as learners in the clinical setting.

Conclusions

The findings strongly suggest that students' reflective narratives are a rich source of information about the elements of both the informal and hidden curricula, in which medical students learn to become physicians. Experiences with both positive and negative behaviors shaped the students' perceptions of the profession and its values. In particular, interactions that manifest respect and other qualities of good communication with patients, families, and colleagues taught powerfully.

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Many medical educators have observed that students' experiences in the environment of the academic health center or other clinical venues are the most powerful determinants of future physicians' perceptions of what pass for acceptable behaviors and values in the

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practice of medicine.[1,2] The supposition is that these critical incidents, not exposures to didactic experiences in the classroom, are the more formative influence.[3,4] Some years ago, Hafferty[5] divided critical incidents and experiential learning exposures into two broad domains. The *hidden* curriculum is the physical and workforce organizational infrastructure in the academic health center that influences the learning process and the socialization to professional norms and rituals. The *informal* curriculum is the student's immersion in the interpersonal *processes* in the academic health center, including interactions between students and their teachers, interactions among the interprofessional participants in medical care processes, and interactions that students experience with patients and their family members. These terms refer to the everyday learning experiences outside formal teaching exposures. Hafferty observed that all these elements of structure and process in our educational institutions have heuristic content; that is, our exposure to them teaches us something about medicine and the medical profession.

Most literature on the hidden and informal curricula is theoretical, not grounded in empirical evidence from measures of students' experiences.[6,7] As educators, we have focused far more attention on how competencies in the domain of technical skills depend on students' experiences than we have on the roots of professionalism and professional values in students' experiences.[8] However, we think it is important to build a significant body of evidence about what students experience in critical incidents that shape their understanding of professionalism and professional values, because these particular kinds of experiences seem to have maximal learning potential.[1,9] There is also a need for deeper understanding of the institutional environment and organizational culture within which such incidents arise.[10,11]

In an effort to add one thread of evidence to the larger fabric of information that needs to be woven, we undertook the present study to focus on a systematic qualitative analysis of what medical students on a third-year clerkship in internal medicine see and experience in their day-to-day lives and what they

report as professional critical incidents, events that taught them something about professionalism and professional values. Our intent in gathering and analyzing such data was to "open a window" on the hidden and informal curricula.

Background and Method

Tools and participants

Since February 2004, third-year students on their internal medicine clerkships at Indiana University School of Medicine (IUSM) have been asked to heighten their awareness of professionalism by recording descriptions of events during the clerkship that they believe express professionalism (or the lack thereof). They were asked to write their descriptions online in a password-protected IUSM educational Web site.[12] Each student is required to submit two such narratives during his or her medicine clerkship. The internal medicine clerkship at IUSM is two months in duration. One month is a required hospital, inpatient-based rotation at either the Veterans Affairs (VA) or public (Wishard) hospital. In the second month, students have an option to select either an additional inpatient-based rotation or an outpatient rotation. Approximately half of the students select an additional inpatient-based rotation.

In instructions to students for recording professionalism narratives, no special emphasis is given to recording either positive or negative incidents. In fact, the framing instructions are quite simple and general: reflect on and write about events, either positive or negative, that "taught you something about professionalism and professional values." To ensure that the students are protected from any potential reprisals, students are given assurance at the start of the clerkship that their stories will not be shared with anyone until after they have graduated from IUSM. The clerkship director—the only person with complete access to these stories—reviews students' entries to make edits needed to ensure anonymity of all involved parties in these narratives. The edited narratives are printed and distributed to students at monthly small-group reflection and discussion sessions facilitated by faculty. The further use of these narratives for the present study and the use of focus-group-based activities to

establish trustworthiness of the analysis were approved by the IUSM institutional review board.

The analyses we report here are based on the thematic, qualitative examination of 272 written narratives collected from 135 third-year medical students during a six-month period from June through November 2007. In this period, 137 students rotated through their medicine clerkships. Most students recorded two narratives; 10 students recorded one narrative, 12 students submitted three narratives, and only 2 students did not submit any.

Analysis

The analysis of the stories included the application of two different coding schemes.

The first, *a contextual descriptive analysis* of the stories, involved coding a systematic sample of 63 (23%) students' stories in a chronologically ordered file (the first seven stories as a training set and every fifth story thereafter). This analysis was conducted by two of us who have a medical background (T.R.V. and T.S.I.), using a coding sheet that had been developed by a larger group of clinician–educators at IUSM. This analysis focused on the setting in which the events took place (hospital versus outpatient care setting), the participants in the story (the "characters" in the narrative in addition to the student narrator), and any emotions explicitly described by the student in the text of the narrative. The first attempt was to search for descriptions of so-called basic emotions (happiness, surprise, sadness, fear, anger, and disgust).[13] Because of the low frequency of these explicitly stated basic emotions, this coding was expanded to include other emotional descriptors explicitly found in the narrative texts (e.g., admiration, disappointment, embarrassment, pleasure, and guilt).

The second analysis, and the primary focus of this study, was a *thematic content analysis* of the stories focused on identifying, through close reading and interpretation of the narratives, the main themes that played a significant role in the students' learning about professionalism and professional values in their day-to-day work environment. This analysis was performed using an immersion/crystallization method

(a thematic narrative analysis framework,[14,15] in which we immersed ourselves in the data and then reflected with "intuitive crystallizations until reportable interpretations" were reached). This qualitative research method requires cognitive and emotional engagement, with reading and rereading of the narratives, until the themes emerge. Emergent themes were recorded in a codebook and refined after each batch of coding.

The codebook for the thematic analysis was largely formed after analysis of the first 50 students' stories. Analysis of this initial body of narratives resulted in the identification of 13 major themes that included a variable number (0–10) of subcategories. While coding the remainder of the narratives, the language of the codebook was refined, and a few subcategories were added when new themes emerged. It should be noted that stories with multiple thematic factors presented a special challenge when trying to decide which single, core theme was being articulated. Whereas the vast majority of students' narratives expressed a clearly dominant theme that allowed for a one-to-one coding (one story coded under one theme), about 10% of the narratives expressed two major themes, each of which played significant roles in the narrative dynamic. Each of the latter stories was coded under two or three separate themes to minimize the loss of the breadth of data from these rich narratives (this resulted in a total count of 300 stories coded).

Ensuring trustworthiness of coding

We took three major steps to ensure the trustworthiness of the coding scheme for thematic content. First, while one of us (O.K.M.) was the primary coder and developer of the coding scheme, two others (T.R.V. and T.S.I.) independently reviewed the coding scheme and the coding of the first 50 students' stories to confirm the suitability of the coding for these narratives. We resolved any lack of agreement that arose in this independent review by dialogue to achieve consensus among all three of us regarding the suitability of the codebook and of the coding of each of the narratives. Second, in cases in which the primary coder was uncertain to any degree about the classification of stories, all three of us read these stories and arrived, through

discussion, at a consensus on final coding. Third, after all analysis was completed, we conducted a "member check" process to test the face validity of the themes identified and to learn whether these themes captured students' experiences. This last process entailed convening four focus groups of IUSM medical students for discussion of factors in their environment that influenced their growth and development as future professionals in medicine—two sessions with 17 third-year medical students (MS3s) and two sessions with 15 fourth-year medical students (MS4s). The student participants in these groups were volunteers available when solicited from a larger random sample of all MS3s and MS4s in January and February of 2008. The MS3 focus group included some students who had completed their internal medicine clerkships already and others who were in their clerkships at the time the focus group was convened. We convened MS4 focus groups to learn whether those students' points of view and perspectives would be different than those of the MS3s, given that the students in the former group were one step closer to postgraduate training than were their less experienced colleagues.

The focus-group member-checking process was conducted as the last segment of a longer group discussion of the educational environment. The member-checking process itself had three components. First, the outputs of the context and content analyses cited above were presented to the focus-group students. We presented the names of the main narrative themes with verbal examples of subcategories and stories in these themes, but without reading actual narratives. Next, the students were invited to engage in open dialogue on whether these main themes "seemed right" to them (reflected their own experiences) and whether something in their experiences was missing. Finally, each student was asked to multivote by choosing the three most important educational influences (among those presented) in his or her day-to-day experiences.

Results

We first report our findings from the contextual analysis, to provide an overview of the narratives' contexts. Next, we present findings from the

thematic content analysis, along with some representative quotes from the students' professionalism narratives, to illustrate the core themes that emerged. Exemplar narratives for all subcategories are available on request from the corresponding author. Finally, we present the findings from the member-check feedback and the students' choices of the three most important educational influences.

Context

Most of the students' stories (48; 77%) described experiences in the hospital (inpatient) setting, whereas a fifth of the stories (13; 20%) were based on their experiences in the ambulatory clinic (outpatient) setting—a distribution roughly proportionate to the time students spend in these settings during the clerkship. In the remaining two (3%) stories, the setting was not stated and could not be inferred. The vast majority of stories involved more than one participant in addition to the narrator. The other individuals in the narratives were patients (53 stories; 84%), attending physicians (23; 37%), residents (16; 25%), interns (16; 25%), family members (12; 19%), nurses (11; 17.5%), consultants (10; 16%), "the team" (9; 14%), other physicians (5; 8%), other students (3; 5%), and all other individuals combined (e.g., physical therapists, laboratory technicians) (10; 16%).

In our attempts to identify the students' emotions in their narratives, we found that only 12 (19%) of the stories' texts included any emotional content that could be coded.

Thematic content

The 272 experiences described by the students were coded as positive in 172 (63.4%) of the stories and as negative in 80 (29.1%). The remaining stories were "hybrid" narratives that included both positive and negative elements (20; 7.5%). One kind of hybrid story included descriptions of two events that contrasted one person's positive professional behavior with another person's unprofessional behavior. The other hybrid story type was the "damage and repair" narrative, in which a participant initially acted in an unprofessional manner but then took responsibility and corrected the situation in a positive

professional manner (e.g., took responsibility and discussed the situation with the patient and/or student).

Thematic analysis of the students' stories revealed two main domains, one focused on the medical–clinical interaction (244; 81.3% of the stories) and another focused on the teaching and learning environment (56; 18.6% of the stories). Stories focused on medical–clinical interaction included narratives in which the students described observations of various role models who interacted with patients, families, coworkers, and colleagues. The stories about the teaching and learning environment focused more on the students' experiences as learners in the clinical setting. The entire taxonomy with distribution of stories to major themes, subcategories, and positive, negative, and hybrid stories is presented in Tables 1 and 2.

The medical–clinical interaction domain (Table 1) consisted of six key thematic categories, with as many as 10 subcategories. Each theme and subcategory included both negative and positive stories describing either unprofessional or professional behavior. Parsing the narratives into major themes was based on the main issue and/or challenge described in the narratives. For example, in some stories, the focus was on *managing communication challenges*; in some other stories, the focus was on *spending time taking care of patients and patients' education and understanding* (a related but discernibly different narrative emphasis). In some theme titles, the actual participants were mentioned. Some stories were exclusively about interactions with patients, others were about patients and family members, and yet others were about interactions with other health care professionals.

The most common theme in the students' stories was denoted *manifesting respect or disrespect in clinical interactions with patients, families, colleagues, and coworkers*. Descriptions of respectful behaviors included actual face-to-face interactions with patients or colleagues (conversations and acts in the presence of others) as well as descriptions of behaviors and conversations that referenced patients or colleagues in their absence (behind closed doors). Here is a sample narrative illustrating the subcategory of respecting patients' decisions:

Table 1

Thematic Content of Students' Professionalism Narratives Within the Medical–Clinical Interaction Domain, Internal Medicine Clerkship, Indiana University School of Medicine, 2007*

Theme	% of 272 stories	Subcategories	No. of positive stories	No. of negative stories	No. of hybrid stories	Total no. of stories[†]
Manifesting respect or disrespect in clinical interactions with patients, families, colleagues, and coworkers	26.8	Respecting patients'/families' decisions, wishes, or needs	9	3	0	12
		Acting respectfully with patients/families in challenging situations	9	2	0	11
		Having disrespect toward/from colleagues	0	10	0	10
		Treating patient as a person and not a disease carrier	5	3	1	9
		Using appropriate language/interaction with a patient / colleague	6	4	1	11
		Being respectful to stigmatized populations	3	2	1	6
		Using inappropriate humor/comments (behind the patient's back)	1	4	0	5
		Criticizing others	1	3	0	4
		Showing disrespect toward the profession/ negative attitudes	0	1	0	1
Managing communication challenges with patients and families	18.6	Handling difficult situations/conversations with patients / families	18	2	2	22
		Communicating in a caring and compassionate way	12	2	0	14
		Communicating with angry/resistant patients or families	12	1	0	13
Demonstrating responsibility, pride, knowledge, and thoroughness	16.2	Displaying responsibility, honesty, and integrity	17	11	3	31
		Acquiring updated knowledge/lifelong learning	4	1	0	5
		Thoroughly investigating patients' problems	4	0	0	4
		Striving toward excellence	2	0	0	2
		Acknowledging your limitations	1	0	0	1
		Having pride in work	1	0	0	1
Spending time taking care of patients, patients' education, and understanding	16.2	Spending time to talk and answer patients'/ families' needs for information and support	19	5	3	27
		Spending time with patients, listening respectfully, learning their history and concerns	6	2	0	8
		Communicating in a level/language that patients can understand	4	0	2	6
		Taking full responsibility for patient care and informing health care providers and caregivers	4	0	0	4
Going above and beyond, caring, and altruism	8.0	No subcategories	19	3	0	22
Communicating and working in teams	4.8	No subcategories	6	7	0	13
Unclear stories	2.9	General comments without a specific story				8

* This table's information is based on findings of a thematic analysis of 272 professionalism journal entries written by 135 students in 2007 describing experiences in their internal medicine clerkships that "taught you something about professionalism and professional values." The table displays themes and thematic subcategories identified under the medical–clinical interaction domain, which included 81.3% of all the journal narratives.

† The total number of stories exceeds 272 because sometimes a single story was classified more than once across themes.

A patient was in need of a rectal exam to test for occult blood due to a recent history of black stools. The physician explained the need for the test. The patient refused the rectal exam. The physician offered to have a male physician come in to do the exam in case the male patient would be more comfortable. The patient also refused this. The physician

Table 2
Thematic Content of Student Professionalism Narratives Within the Teaching-and-Learning Environment Domain, Internal Medicine Clerkship, Indiana University School of Medicine, 2007*

Theme	% of 272 stories	Subcategories	No. of positive stories	No. of negative stories	No. of hybrid stories	Total no. of stories
Creating an (un)welcoming environment	6.6	Respecting colleagues/learners from lower hierarchies	2	7	2	11
		Being tolerant to mistakes, providing constructive feedback and evaluations	3	2	0	5
		Included and acknowledged as a medical student	1	1	1	3
		Judgmental environment	0	1	0	1
Capitalizing on teaching opportunities	6.6	A leader who teaches—asks questions, explains, spends time, learns	14	0	0	14
		Using opportunities to teach values and manners	3	0	0	3
		Giving safe and structured responsibilities	1	0	0	1
Learning from peers	3.7	Fellow student teaching and helping other students (demonstrating teamwork)	3	0	1	4
		Fellow student relating to a patient as a person	5	0	0	5
		Taking care of fellow colleagues	1	0	0	1
Dealing with attending/staff or self expectations	1.1	Unclear expectations from attending and staff	0	2	0	2
		Self expectations as a professional	0	1	0	1
Paying attention to students' needs	0.7	Attuned to students' personal needs/life situation	1	0	0	1
		Caring for students	1	0	0	1
Having space to conduct private conversations	0.7	No subcategories	0	1	1	2
Demonstrating honesty and integrity	0.4	No subcategories				1

* This table's information is based on findings of a thematic analysis of 272 professionalism journal entries written by 135 students in 2007 describing experiences in their internal medicine clerkship that "taught you something about professionalism and professional values." The table displays themes and thematic subcategories identified under the *teaching and learning environment* domain, which included 18.6% of all journal narratives.
† The total number of stories exceeds 272 because sometimes a single story was classified more than once across themes.

did not push the patient and respected his decision without showing anger or frustration.

This story focuses on respecting a patient's right to make a decision regarding his or her care. There is no evidence of pseudoshared decision making and no coercion. This physician tries to understand and respond to her patient's possible concerns by first offering to step aside and ask a male physician to do the exam and then by accommodating the patient's refusal.

Whether or not this action was medically preferable, the patient's autonomy was respected and supported.

The second-most-common theme focused on *managing communication challenges with patients and families.* These stories were about the way conversations in various situations proceeded. Most of the stories in this category were positive; that is, students were impressed by the positive manner in which professionals handled these

communicational challenges. However, some of the stories focused on unsatisfactory ways of handling sensitive conversations.

An 85-year-old male with lung cancer and prostate cancer came into the ER and was placed on our team. It was obvious he and his family were unaware of his grave prognosis. After being on our service for days, one of our team members decided it was time to make sure he (the patient) understood how grave his prognosis was. He didn't ask if the man would like some privacy or if he wanted his family in the

room at the time. Our team member started the conversion with "I am surprised you are still with us. I thought you would be dead after the first two days." Needless to say the family became very upset and the patient wasn't too pleased with the comment as well.

This example documents the student's awareness of challenging communication situations (e.g., communicating a grave prognosis) as critical incidents in medical care and also of some of the consequences of handling these challenges inappropriately.

The third-most-common theme named *demonstrating responsibility, pride, knowledge, and thoroughness* included descriptions of the actions of role models that demonstrated either poor or exemplary behaviors. Most of these stories focused on such matters as taking responsibility for your own mistakes, being honest with others (patients, students, and colleagues), and manifesting integrity in completing paper or computer work. Other stories in this theme focused on excellence in patient care. The following is a partial narrative that was classified in this thematic category as a breach of excellence in patient care:

> I've been surprised by some of the poor technique of my private doctors and also some of their medical decisions.… A new patient had come in for a physical exam and also for a referral to see an orthopedic surgeon because she had a history of hip fracture/repair. She was ready to have children and wanted to get checked out. This private doctor did not agree with the patient's getting a referral because he didn't find it very important at the moment. He told her to get pregnant, then he would send her to orthopedics. I could tell that this patient was very concerned about her hip and really wanted a referral. He still denied her request. He felt like this patient was difficult and decided that he did not want to be her doctor. He asked her to find a new doctor and left. I felt very bad for this patient. She had tears in her eyes. I apologized and she left.

This narrative reveals the complexity of the coding task and the richness of students' reports. It contains elements that touch on physician responsibility, acknowledging limitations, sensitivity to patient needs, accepting patient preferences, and dealing with disagreement. Though the narratives infrequently included explicit information about how the student protagonist actually felt in a situation, in this exceptional narrative, the student expressed his or her own feelings of helplessness. It is also noteworthy that the student felt the need to apologize for the nature of the interaction and an apparent act of abandonment.

Narratives in the fourth-most-common theme category focused on *spending time taking care of patients and patients' education and understanding.* These stories were about professionals taking time to understand their patients' concerns and needs and making certain that patients understood what was being said about their illnesses. In the following narrative, a student reported a fellow student taking responsibility for a patient's education.

> Another student relayed a story about one of her patients. Apparently, nobody had ever discussed with the patient why they were having certain symptoms, what her diagnosis might be, and what her medications and tests were for. She stated that she sat down with the patient for 30 minutes and explained everything to her. Not only does the patient deserve this, but it will help with medication compliance and decrease readmissions. The medical student recognized this and showed initiative and responsibility by taking this time for the patient.

This narrative underlines the importance of spending time with patients. Time was mentioned often in the students' narratives, usually in appreciative stories that reported people who took time to teach, explain, or listen. Spending time was presented as a positive act (a kind of altruism) meant to fulfill patients' needs, and it also was presented as a physician's behavior that improved the quality of patient care and increased the likelihood of patient compliance to treatment recommendations. One of the common observations of students was that the time spent in patient education was a worthwhile professional investment.

Narratives in the fifth-most-common theme category focused specifically on *going above and beyond,* caring and altruism in taking care of patients and/or family members.

> This month, I had my first encounter with an HIV patient who also had AML with neutropenia, was bipolar, and likely had a very finite amount of time left to live. His seeming "last wish" was to make his airline flight approximately two weeks from his DOA so that he could attend his daughter's college graduation. This patient had several consulting physicians looking after his health. I was impressed by the "going beyond the call of duty" that the VA staff displayed on this patient, with everything from saying "treat this person as if it were your parent trying to attend your graduation" to contacting the airline service for arrangement of a wheelchair and special services during his flight. Each physician involved showed genuine compassion and caring for this person in more aspects than his current medical status. From this experience, I really got a sense of the multidisciplinary cooperation required for complete patient care.

The last theme category in the medical–clinical environment domain included stories concerning *communicating and working in teams* and about the issue of teamwork.

> The attending, residents, and interns on my service ignored the pharmacy student on rotation with our team. I don't know if it was arrogance, pride, vanity, or a combination of them, but they never praised the student for anything he suggested that was correct nor did they ever take the time to teach or learn from the student. I was embarrassed for myself and everyone involved.

Teamwork and relationship with colleagues and coworkers was a latent or subdominant topic in almost 10% of the stories (in different themes).

The remaining 18.6% of the students' stories focused on the teaching and learning environment (Table 2). Almost half of these narratives were classified under the theme named *creating an (un)welcoming environment.* The following is a hybrid narrative that includes both a negative and a positive experience in the teaching environment:

> Throughout this month, I had the opportunity to work under two different physicians. The first had a great attitude at all times. He would pimp us [i.e., put us on the spot] on a regular basis; however, I never felt uncomfortable missing a question, or saying "I don't know the answer." I often spent long days on his service, but I enjoyed every day and learned an incredible amount about medicine, how to treat patients compassionately, and how to be a real leader who made each team member feel appreciated. Unfortunately, the second physician was quite different. Her business-like and cold attitude made the rest of my service much less enjoyable— and the rest of my team, previously with

constant smiles, now looked irritated at being at the hospital. In addition, when pimped, we were made to feel inferior if we did not know the correct answers. I'm glad that we had the prior staff, because I believe that if I had had the latter physician during the whole service, I would not be considering medicine as a career choice.

The feelings of being actively taught, appreciated, and cared for seemed to be extremely important to students. They are greatly affected by the quality of environment that the attending physician creates, one that makes them feel motivated or discourages them as learners. So powerful is this teaching and learning microsystem that a particular behavior—denoted by students in their vernacular as *pimping* (i.e., deliberately putting trainees on the spot to highlight the limitations of their knowledge)—may be acceptable or not to them depending on the relational dynamic and context. This narrative illustrates the power of these experiences in shaping a student's perceptions of an entire medical specialty and his or her suitability for a career within it.

The other large theme category in this domain focused on educators' *capitalizing on teaching opportunities*: situations in which a leader encouraged learning and taught by asking questions and providing explanations, using all opportunities to teach values and manners. All stories in this theme were positive. Students seem to appreciate these behaviors and opportunities:

> A staff physician had a patient in the ICU who was not doing well and needed a lumbar puncture. The physician sought out a resident physician to do the procedure since he/she had never performed one. I thought this extra effort and dedication to teaching was fabulous. Additionally, the staff asked me—the student—to gown and glove to help, rather than he doing it personally. It was nice to be put in a position to be part of the team and help. Plus the staff doctor was incredibly patient in talking the resident through the procedure, taking time to answer questions and give advice without hopping in to help physically or take over the procedure. His patience was truly remarkable and his dedication to teaching and sharing experiences is an example I will certainly hope to emulate. He is well read and well trained and wants us to be as well. Kudos to him.

When faculty members spent time on teaching skills, values, and manners, their efforts were noted and greatly appreciated by students. Here, the learner appreciates the opportunity he or she received to learn from active participation, rather than from observation only. Students also expressed great satisfaction and appreciation when they were included and treated as junior colleagues who were part of the team.

Other, smaller thematic subcategories focused on fellow students' roles in demonstrating teamwork and professional behavior with patients, dealing with attendings' and staff members' expectations, students' expectations regarding their role, paying attention to students' needs, and having space to conduct private conversations.

Member check

In their respective focus groups, both the MS3s and MS4s recognized and positively affirmed the major themes and thought the domains and themes reflected and fairly described the content of their experiences. No themes were disavowed or seen as irrelevant. No additional themes were suggested. The summary results of the multivoting, and a comparison of the MS3 and MS4 votes, are presented in Table 3. By Fisher exact test, it seems that the relative importance ratings by MS3s and MS4s of their educational experiences differed ($P = .04$). Nearly two thirds of the participating MS3s rated "manifesting respect" as very important (12 of 17 students included this theme among their three most important themes), followed by "creating a welcoming environment." By contrast, MS4s stressed the "importance of taking (and being given) responsibility for patient care" and "capitalizing on teaching opportunities."

Discussion

The analyses described above suggest that the hidden and informal curricula are rife with events and experiences that students see as "teaching them something about professionalism and professional values." In our institution, inviting students to record narratives of their experiences in a personal professionalism journal has created a rich vein of reflective journaling for small-group facilitated student dialogues, residents' training, faculty development, and systematic qualitative assessment of the professional environment of the school of medicine. If experiential learning in the informal curriculum is the most powerful determinant of future professional behaviors, our students are learning across a broad spectrum of content. We are struck by their attention to the quality of interactions and relationships in the environment—both clinical and educational. Judging by their narratives, our students attend closely to the respectfulness of these interactions, the extent to which people's (patients' and students') needs are met, the appropriateness and supportiveness of the microenvironments for these interactions, the comprehensiveness and sensibility of communication in these environments, the generosity with which people commit their time in the interest of others, and the attitudes (positive or negative) with which people make their choices and take their actions.

We have honestly been surprised by the balance of positive and negative narratives, with a greater proportion of positive narratives than have been found in similar collections of reflective writing in other settings.[16] We had thought students might use the professionalism journals to record their complaints. With no instructions in this regard from supervising faculty, however, our experience shows that students reflect and write at least as often about positive exemplars and their actions as they write about negative ones. It is exciting and encouraging to think that they are hungry for these kinds of positive experiences with others.

We are also struck by the relative paucity of language in these narratives that explicitly records the students' emotional responses to the events they have seen unfold. Because we were able to code only explicit student affect in less than a fifth of the stories, this element of the analysis failed. As coders, we had believed we might infer how a student "must have felt" in a situation, but the students themselves did not record this information. It is as though medical education socialized students to quell their emotions so thoroughly that feelings simply would not rise to consciousness, even when they were reflecting on an experience with special meaning for the students. That the emotional challenges of becoming a physician are a taboo topic in medical training has been noted as an important element of the hidden

Table 3

Comparison Between Third- and Fourth-Year Medical Students' Choices of Three Most Important Themes, Indiana University School of Medicine, 2007*†

Domain with themes	Third-year students' absolute votes: No. (%)	Fourth-year students' absolute votes: No. (%)
Medical–clinical interaction domain		
Manifesting respect or disrespect in clinical interactions with patients, families, colleagues, and coworkers	12 (27.9)	6 (15)
Managing communication challenges with patients and families	2 (4.7)	0 (0)
Demonstrating responsibility, pride, caring attitudes,† knowledge, and thoroughness	4 (9.3)	6 (15)
Taking responsibility for patient care, patients' education, and understanding	3 (7)	8 (19.5)
Communicating and working in teams	3 (7)	0 (0)
Going above and beyond for patients‡	2 (4.7)	0 (0)
Teaching-and-learning environment domain		
Creating an (un)welcoming environment	7 (16.3)	2 (5)
Capitalizing on teaching opportunities	6 (13.9)	8 (19.5)
Learning from peers	0 (0)	0 (0)
Dealing with attending/staff or self expectations	2 (4.7)	2 (5)
Paying attention to students' needs	2 (4.7)	0 (0)
Having space to conduct private conversations	0 (0)	0 (0)
Demonstrating honesty and integrity	2 (4.7)	6 (15)

* This table displays multivote data from four focus groups: two groups of third-year students (17 students) and two groups of fourth-year students (15 students) as they responded when asked to vote for "the three most important factors that affect your professional growth and development."

† The relative-importance ratings of the third- and fourth-year students differ significantly (Fisher exact test, $P = .04$).

‡ When presenting the themes to the focus-group students, the subcategory of caring attitudes was a part of the larger theme of demonstrating responsibility, pride, caring attitudes, knowledge, and thoroughness, and not of going above and beyond for patients. Later on, while finalizing the manuscript and further analyzing the data, caring attitudes was moved to the theme of "going above and beyond, caring and altruism."

curriculum,[17,18] reflecting the culture of Western biomedicine's tendency to objectify disease to the neglect of the subjective experience of illness and healing.[19,20] Students feel enormous pressure to prove themselves worthy of the profession, and tacit signals from classmates and faculty very often convey the message that inadequate emotional control can lead to academic and professional failure.[17] Students' reflections on critical professional events, without acknowledgement of the accompanying "emotion work"[21] those events demand, suggest that norms against displaying or even perhaps feeling and/or acknowledging emotion are as powerful as ever. When students are too successful at closing off, blunting, and suppressing their emotional reactions to training, they lose a measure of their humanity and sensitivity to their own experience.[18] Encouraging students to work through their emotions "out loud" (such as group discussions and reflective writing) may help them develop greater resilience to absorb the positive messages and resist the negative messages to which they are exposed.

From our findings, we observe that there is both good news and bad news for faculty attending physicians—the most prevalent figures in the present study's student narratives—about how and when students are learning about medical professionalism. The good news is that students are learning continuously. Both medical–clinical care interactions and learning and teaching interactions are significant in evaluating faculty members' professionalism. Students observe and learn from their mentors' behavior in different kinds of situations, both those that are visible to the participating people and those behind closed doors; in particular, they observe how their mentors interact with various others (patients, family members, nurses, other physicians, and fellow students). The bad news for faculty is the same as the good news—students *are* learning *all* the time and expect us, their faculty, to act in a professional manner at all times. They focus, in some important respects, on the *consistency* of our behaviors, which they think reflects our character and our integrity. In this regard, they agree with H. Jackson Brown, Jr,[22] who wrote that "our character is what we do when we think no one is looking." It is for these reasons that student narratives, in certain respects constituting a "360-degree" measure of faculty behavior, may have special value as a resource for faculty development as well as for student learning in the medical school environment.

The feasible aim for faculty behavior is not perfection. Negative critical incidents, which will occur in the real world we occupy, may themselves play a constructive role in shaping students' perceptions of their faculty and the choices students make in future circumstances. In our study, students' negative narratives included reflections on learning how not to do things as well as noting the adverse consequences of negative behaviors on themselves and on others. As many have noted, when a breach or a lapse comes to light within our organizations, we need to deal with such events in a manner that will enhance learning, repair what can be repaired, and maximize the likelihood of future positive professional behavior. Encouraging mindfulness to these kinds of situations, reflecting on them, and understanding what went wrong, their emotional content, and their negative influences on the self and others are the first steps of the learning process toward changing the environment. Students' narratives can serve as an instrument for such learning.

The findings of this study, as well as of an earlier study,[23] emphasize the importance of a positive teaching and learning environment, especially the need to

create a "welcoming" atmosphere that is interpersonally safe and capitalizes on teaching opportunities as they arise. Themes in our student narratives suggest that key elements in such an environment include respectful relationships, eagerness to teach, tolerance for mistakes, constructive feedback, and teamwork among the students.

Though learning and teaching environment stories were discussed in only 55 (20%) of the written narratives, in the multivote regarding their importance they were rated almost as frequently as were stories within clinical–medical environment themes: 19 votes (45%) among MS3 and 18 votes (55%) among MS4 students. Conversely, an unwelcoming and unsafe learning environment may truly be toxic. An earlier study suggests that an environment that elicits students' negative emotions has long-term negative effects on learning and relationships with other professionals and patients.[24]

The difference in the relative importance ratings of our themes by MS3s and MS4s is noteworthy. It seems that the MS4s paid more attention to clinical processes and the character of the professionals with whom they work, expecting them to act as role models and demonstrate responsibility, honesty, and integrity. The MS3s were more focused on the general environment created: whether it is welcoming, respectful, manifests good team work, and is attentive to students' needs. The MS3s seemed to expect their role models to teach them, but the MS4s expected to take (and to be given) more direct responsibility for their learning. From the discussions and importance ratings at the focus groups, we could surmise that maturing students become more experienced and confident and in their fourth year expect more of themselves, in terms of actually relating to patients in a professional manner. They expect faculty to provide them with the opportunity to practice their skills. Another way to characterize the difference between the years is that the MS3s were primarily functioning as observers of others' behavior, whereas the MS4s were becoming more active participants in clinical and educational work themselves. This evolution in the student's role, expectations, and perceptions requires a coevolution in the student's relationships and interactions

with faculty. Although we are tempted to assert this finding as an effect of student maturation, we should also note that our focus groups, as it happened, had a gender mix that differed. There were twice as many women (11) in the MS3 group than men (6), and twice as many men (10) in the MS4 group than women (5). Although we have been unable to document gender professionalism theme propensities in other (unpublished) analyses, this topic deserves further exploration.

This study has important limitations that we should note. The data were collected from only one institution, and the narratives were based on students' experiences in only one clerkship. There is a need to further explore students' experience in more diverse institutions and clerkships. We are able to comment only on the experience of third-year and partially on fourth-year students in this particular environment and not on the broader process of socialization of students through the longer educational process— or even on how prior experiences on other clerkships might influence their reflections when they rotate through their medicine clerkship. Finally, it would be helpful to know whether particular student experiences have more impact than others as time passes and the immediate effects dissipate.

With all these caveats, we nevertheless conclude that reflective narratives reporting professionalism critical incidents are a rich source of new information about the content of the hidden and informal curricula and the environment in which medical students learn to become physicians. Experiences with both negative and positive behaviors shape students' perceptions of the profession and its values. Many of the formative experiences focus on interpersonal relationships and interactions within these relationships that manifest respect and other qualities of communication with patients, families, and colleagues. Such narratives may constitute an important resource for faculty development as well as student learning.

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Medical Students' Professionalism Narratives: A Window on the Informal and Hidden Curriculum: Correction

In the January 2010 report by Karnieli-Miller and colleagues,[1] some of the data in Tables 1 and 2 and in their footnotes were incorrect. The corrected tables are presented in Supplemental Digital Table 1 Correction and Supplemental Digital Table 2 Correction, which may be found at http://links.lww.com/ACADMED/A37. The corrected data and footnotes language are bolded.

Reference

1. Karnieli-Miller O, Vu TR, Holtman MC, Clyman SG, Inui TS. Medical students' professionalism narratives: A window on the informal and hidden curriculum. Acad Med. 2010;85:124–133.

Professing Professionalism: Are We Our Own Worst Enemy? Faculty Members' Experiences of Teaching and Evaluating Professionalism in Medical Education at One School

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Abstract

Purpose

To explore clinical faculty members' knowledge and attitudes regarding their teaching and evaluation of professionalism.

Method

Clinical faculty involved in medical education at University of Toronto Faculty of Medicine were recruited to participate in focus groups between 2006 and 2007 to discuss their knowledge, beliefs, and attitudes about teaching and evaluating professionalism and to determine their views regarding faculty development in this area. Focus groups were transcribed, analyzed, and coded for themes using a grounded theory approach.

Results

Five focus groups consisting of 14 faculty members from surgical specialties, psychiatry, anesthesia, and pediatrics were conducted. Grounded theory analysis of the 188 pages of text identified three major themes: Professionalism is not a static concept, a gap exists between faculty members' real and ideal experience of teaching professionalism, and "unprofessionalism" is a persistent problem. Important subthemes included the multiple bases that exist for defining professionalism, how professionalism is learned and taught versus how it should be taught, institutional and faculty tolerance and silence regarding unprofessionalism, stress as a contributor to unprofessionalism, and unprofessionalism arising from personality traits.

Conclusions

All faculty expressed that teaching and evaluating professionalism posed a challenge for them. They identified their own lapses in professionalism and their sense of powerlessness and failure to address these with one another as the single greatest barrier to teaching professionalism, given a perceived dominance of role modeling as a teaching tool. Participants had several recommendations for faculty development and acknowledged a need for culture change in teaching hospitals and university departments.

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Professionalism is a tenet of doctoring that is valued increasingly highly by the general public and that provides the basis for medicine's contract with society.[1] Moreover, the Royal College of Physicians and Surgeons of Canada, the Accreditation Council of Graduate Medical Education, and virtually every North American medical professional body and society have deemed professionalism a core competency and mandated medical faculties to teach it.[1–5] All Canadian postgraduate medical specialty residency training programs must provide trainees with instruction and evaluation with regard to this competency.[4] The Medical Council of Canada's two-part licensing exam for all Canadian undergraduate medical students includes examination questions on the CanMEDS role of professionals.[6]

The past decade has seen an explosion of both theory and research on how best to define, teach, and evaluate the knowledge, skills, and attitudes that constitute a physician's professional role,[7–28] and articles have proliferated addressing issues related to assessing and managing unprofessional behavior by trainees.[29–37] There has been a simultaneous increase in institutional position papers and statements from hospitals and universities as well as provincial and national licensing bodies defining the professional behaviors expected of physicians regulated by those institutions.[3,38] However, a gap exists between this burgeoning literature on professionalism and our ability as medical educators to effectively teach and evaluate in this domain.[39,40]

Currently, professionalism continues to receive some attention in training programs, primarily through faculty example and mentoring, yet there is no clear consensus or evidence base to inform best practice, teaching, and evaluation in this area.[28–30,39]

Our purpose was therefore to explore faculty members' knowledge, beliefs, and attitudes about teaching and evaluating professionalism and to determine their views regarding faculty development in this domain. Qualitative research is well suited to explore experiences, perceptions, and beliefs, especially when the phenomena under study are not well

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understood or defined.[41,42] We therefore used focus-group methodology and grounded theory analysis to develop a fuller understanding of faculty members' views.[43–45] We hope this will ultimately lead to a more informed process of design and implementation of faculty development resources and ultimately improve the education of trainees.

Method

Participants and recruitment

Potential participants were clinicians in the Faculty of Medicine at the University of Toronto who had direct teaching responsibilities or who were directly involved with evaluating trainees' professionalism at the undergraduate or postgraduate level. Following approval by the University of Toronto Health Sciences Research Ethics Board and the Hospital for Sick Children's Research Ethics Board, recruitment took place via a series of e-mails to faculty and department list serves. Initial e-mails were sent to the departments of surgery and psychiatry, and then expanded to include other departments because of low recruitment.

Focus groups

We conducted five focus groups between July 2006 and September 2007, consisting of a total of 14 clinical faculty drawn from surgery, psychiatry, pediatrics, and anesthesia. Each group had two to five participants. The number of focus-group participants is in accordance with norms for qualitative research.[43] The focus groups were 90 to 120 minutes long and were transcribed verbatim. Two of us (P.B., N.A.) alternated in the facilitator role. A research assistant took and transcribed field notes while the facilitator conducted the focus groups. Field notes covered the following issues: relevant body language of the participants, such as nods of agreement or dissent; the intensity and fluency of discussion; whether a discussion seemed to generate heat, as might be evidenced by the number of interruptions from participants; and whether a topic seemed difficult, as evidenced by longer silences among participants or apparent reluctance to discuss certain issues in depth. Probing questions were not used after the initial structured questions. The groups tended to flow well, with few silences or hesitations. Follow-up

questions focused on clarification or the generalizability of a participant's experience to other group members. Transcriptions were rendered anonymous before being analyzed; however, two of us (P.B., N.A.) were present for the focus groups and were known to some of the participants.

In the focus groups, faculty were asked to comment on a set of questions designed to elicit their thoughts and attitudes toward defining, teaching, and evaluating professionalism for medical trainees. These questions were

- What is professionalism for physicians?
- Who defines it?
- What is unprofessional behavior?
- How is it learned?
- How is it taught?
- How does unprofessionalism arise?

We developed these initial questions in collaboration with academics and teachers in the faculty of medicine at the University of Toronto, with expertise both in conducting focus groups for the purpose of qualitative research, and in teaching and evaluation of professionalism in medical settings. These questions evolved and were refined during and after each focus-group session in accordance with the theoretical underpinnings of grounded theory research.[44,45]

Coding of transcripts

We coded the transcripts for emerging themes according to grounded theory research methodology in which substantive theory is derived through an ongoing process of continually reviewing the data, refining categories, and reevaluating these changes.[44] Three of us (P.B., N.A., S.G.) independently read transcripts and highlighted recurring issues, examples, or quotes. We then discussed and iteratively revised the key emerging themes and interpretations. These discussions resulted in the grouping of dominant and pervasive ideas we identified as categories. Once the coding was deemed complete (i.e., saturation was achieved, defined as the point at which no new ideas or themes were generated), one author (B.K.), a trained research assistant, coded all transcripts using N-Vivo qualitative analysis software (QSR International Pty

Ltd., Version 8, 2008). The first three authors (P.B., N.A., S.G.) met regularly with the research assistant to review and validate the N-Vivo coding. One of us (S.G.) has had extensive experience in qualitative research studies and in using N-Vivo software, and spent time individually reviewing all of the coding. All the investigators subsequently reviewed the N-Vivo codes for accuracy.

Results

The demographics of the study group are described in Table 1. A predominance of psychiatrists and surgeons among the participants reflected our initial recruitment focus on those specialties, as they match those of the two lead investigators and we were interested in exploring potential differences between faculty based on specialty. However, we had difficulty recruiting the number of faculty we had hoped for and therefore expanded our recruitment efforts to other departments. Despite this wider scope for recruitment, the number of faculty agreeing to participate in the

Table 1

Characteristics of 14 Participants in Faculty Focus Groups on the Subject of Faculty Teaching and Evaluation of Professionalism, and Perceived Need for Faculty Development, From the Faculty of Medicine, University of Toronto, 2006–2007

Characteristic	No.
Gender, male/female	8/6
Specialty	
Psychiatry	6
Pediatrics	1
Surgery	6
Anesthesia	1
Years in practice	
0–5	2
6–10	5
11–15	3
16–20	0
>20	4
Role in education*	
Teaching	14
Administration	6
Leadership	1
Research	3

* All participants were engaged in teaching in addition to one other role.

groups was lower than we had anticipated.

The five focus groups yielded 188 pages of textual material. Our analysis revealed three major thematic categories: (1) Professionalism is not a static concept, (2) a gap exists between faculty members' real and ideal experience of teaching professionalism, and (3) "unprofessionalism" persists. These thematic categories comprised 12 subthemes illustrated in Table 2.

Professionalism is not a static concept

A participant from Focus Group 2 noted, "I still think that our definition of professionalism is governed by social mores that are unwritten but are constantly evolving, changing, being redefined, becoming more sophisticated in their definition or in their perspective." This quotation exemplifies the notion that professionalism is a concept in flux.

Within this thematic category, six clear subthemes emerged, all deriving from faculty members' experience of professionalism as difficult to define. This difficulty was emphasized in all the focus groups. Specific illustrations of the subthemes are provided in Table 2. Despite the plenitude and depth of the participants' responses to the question regarding definition, the participants had difficulty in settling on a single definition, a function of their perception that professionalism actually has multiple potential bases for definition. These bases included those chosen by and characteristic of the particular group defining it; moral or ethical frameworks; specific behaviors; definitions of exclusion (i.e., what professionalism is not); values, qualities, and attitudes; and, finally, the notion of professionalism having an intangible nature that does not lend itself easily to definition.

The most widely explored subtheme stemmed from faculty members' understanding that particular groups provide differing definitions of professionalism, according to each group's specific codes of conduct and legal frameworks, the influence of its specific medical context, geography, culture, gender and generational balance, and its societal background, which encompassed media, culture, economic framework for health care, and religion.

For example, faculty described different professional cultures specific to different specialties, with the surgeons in particular referring to the unique nature of their role as "captain of the ship" in the operating room and the assumption of responsibility entailed in that role and the peculiar stresses of their work. One participant talked about the differences inherent in a surgical notion of responsibility:

> I think [for surgeons] the whole responsibility thing is of primary importance because people can actually die if you don't make sure that the XYZ gets checked . . . . We blow it up beyond where it needs to go [sometimes] but the message is that you have to take responsibility for things that you do and it has direct consequences *tonight*. Whereas in other specialties, you do have to take responsibility but it may have consequences in two weeks. You may have a little bit of time, it's a little bit different.
>
> ——Focus Group 1

In addition to cultural differences between specialties with regard to definitions of professionalism, faculty identified the sometimes conflicted relationship that exists between different societal influences on the medical group: for example, between the public's notion of an ideal physician, the health care field's increasing focus on team work and multidisciplinary collaboration, and the economic structure of modern health care and research.

They pointed to the plethora of idealized television physician–heroes who are portrayed in ways that are far from the day-to-day experience of most physicians. One group talked about *House* (a popular and critically acclaimed U.S. medical television show), in which the abrasive, drug-addicted physician–hero plays an individualistic, cowboy role and places individual patient benefit before all other priorities, in contrast to the conservative, liability-conscious administration of the large teaching hospital where he works. One interviewee remarked,

> [*House*] is about a doctor who does many things we would consider unprofessional and yet I do think that there's a cultural context where certain people are given the purview to act this way [because] it reassures people of their technical ability . . . . I'm sure if you asked people

> . . . "Would you go to someone like *House*?" they would all say yes.
>
> ——Focus Group 2

Another participant reflected on how the doctor of *House* refuses in one episode to promote a new drug despite pressure from his hospital to do so, and contrasted this with the medical profession's complacency regarding its relationship with the pharmacological industry.

> I think the largest conflict of interest we have not managed as a profession is our relationship with the industry. And it is one of those things that the media has become well aware of, that more and more people are talking about . . . we really have to grapple with and have a coherent response.
>
> ——Focus Group 2

A gap exists between faculty members' real and ideal experience of teaching professionalism

A participant from Focus Group 1 remarked, "I don't think that there's a forum [where] people can discuss these things [and] they don't feel judged. I don't know how you do that; I'm sure it's not with staff people . . . . I don't think you can talk about the stuff that you've really screwed up."

This second major thematic category arose from participants' discussion of their current teaching and learning strategies as well as their perceptions of more desirable approaches. The category's two subthemes distinguished between faculty members' perceptions of how professionalism is learned and taught and the participants' ideas of how it should be taught. Discussion of the subthemes identified the teaching and learning that occur explicitly in the formal curriculum as well as the implicit learning and teaching inherent in the informal and hidden curricula. Participants also discussed the importance of integrated, context-specific teaching, encouragement of self-reflection on the part of both faculty and trainees, and a nonjudgmental teaching environment; see Table 2 for examples.

Faculty identified large-group didactic formats for specific discussion of institutional and legislative codes of professionalism as a current teaching method, but they saw a limited role for these approaches, feeling the real "meat of the matter" lay in role modeling and in

Table 2

Themes That Emerged From Qualitative Analysis of Five Faculty Focus Groups on the Subject of Faculty Teaching and Evaluation of Professionalism, and Perceived Need for Faculty Development, Faculty of Medicine, University of Toronto, 2006–2007

Theme or subtheme	Example or quotation
Theme: Professionalism is not a static concept	
Definition can be based on the group defining it	Codes of conduct, legal documents:
	• "Professionalism is defined contextually and it is changing constantly as a society, the world is evolving, etc."
	• "Regulated Health Professionals Act."
	• "College of Physicians and Surgeons."
	• "There are also legal definitions of what is professional and what isn't, again, which is only a part of it."
	Specific medical context/cultures:
	• "It becomes complicated if you're looking at multiprofessional evaluations . . . . Different professions will have a different sense of what professionalism is."
	Society, media, culture, religion, etc.:
	• "I do think that [professionalism] is culturally determined."
	• "The definition of what is professionally acceptable or unacceptable changes over time as the culture changes."
	• "I think that professionalism is defined contextually and it is changing constantly as society, the world, is evolving."
Definition can be based on moral or ethical frameworks	• "I think ethics and integrity are a big part of professionalism and having a caring approach to your patients."
	• "I simplistically refer to professionalism in two components. One is technical competence and the other is moral competence."
Definition can be based on specific behaviors	• "To me it has to do with following through, being on time . . . being reliable, turning over information appropriately . . . things that are not a function of knowledge or skill but are critical to making sure that things get done for the patient."
	• "For me professionalism is good behavior. It's the way we want doctors to behave . . . not just with patients but with students, with our colleagues."
Can define it by what it is not	• "The line in the sand tends to be a lot of 'let's codify it' in terms of the 'thou shalt nots.' The 'thou shalts' are tougher I think to quantify, to measure. We have a shared sense of what's the right thing to do, and a much a more articulated sense of what's the wrong thing to do."
Can define it based on values, qualities, or attitudes	• "It's the people who teach you, who mentor you, and probably some preconceived ideas of what the profession should be. You grow up on *Reader's Digest* or something and it's the farmer out there who dreams to become a doctor and then helps all the people and gets chickens in return. You think of things like that and so it's probably from your social experiences, possibly your family, and then I think the culture that you grew up in in the medical school, but I don't think it's explicit."
	• "Erik Erikson what he said, give me a child at 5 and I'll give you the man or the woman, so we're products of our upbringing as well. So what we bring from that as well."
	• "In the sense of what defines your identity; it's not how you dress necessarily, it's a collection of behaviors and responsibilities and attitudes."
It's hard to define because it's intangible	• "I think it's an abstract concept."
	• "In a way it's such a broad concept that it's hard to say anything about it without feeling like you must be leaving something out."
	• "I can't define pornography, but I know it when I see it."
	• "It's one of those things that when you sit in rounds and you talk about 'what is professionalism,' it's something, you know . . . it's very difficult to put into words."

(*Continues*)

Table 2
(Continued)

Theme or subtheme	Example or quotation
Theme: A gap exists between faculty's real and ideal experience of teaching professionalism	
Perceptions of how it is learned/taught	Formal curriculum: • "I mean there are some parts that you can teach—the rules, the huge violations you can teach, and it's worth teaching some of those things." Informal or hidden curriculum: • "You can have professional conversations on every single patient you see . . . . The idea is making what's implicit explicit." • "I think everyone of us could think of a doctor that we met in our training which would be, that's the kind of doctor I'd like to be." • "I definitely see the role modeling." • "It's probably an iterative process that is as much a part of the environment one's working in as what the person's bringing to the environment." • "You pick up on the style of whatever leader you're following at the time." It can't be taught: • "So to me those are kind of, I guess motherhood issues; that the idea of trying to teach somebody to do that, I mean, it just seems if you don't get that that's what you're supposed to do, there's no hope."
Ideas of how it should be taught	It should be integrated and context-specific: • "I think we need to bring it to [the] bedside and it will become relevant and meaningful." Through self-reflection: • "Teaching a concept of looking at yourself and who you are and asking those kinds of questions of yourself." Nonjudgmentally: • "I think it's that it's not in front of other people, that somehow what they convey is not I'm mad at you or I'm annoyed with you, it's more I want you to think about this a little bit." • "Maybe just discussing it, too. I don't think that there's a forum that people can discuss these things that they don't feel judged." • "They just want to see that we're as vulnerable as them. We don't have to have answers, but we're prepared to talk about it. There isn't a real easy comfort zone . . . but I think by talking about it and sharing some, 'yeah, I also grapple with this and I didn't know what to do, but this is what I did and these are my reasons.' They don't expect us to have answers because they're not really answers but just to show our humanity and also our vulnerability."
Theme: Unprofessionalism is a persistent problem	
Professionalism is not taught	Because it's hard to define: • "We don't have a language to label it, we don't have a clear construct to define it and therefore we don't have a good way of measuring when it's not working." • "I think it's because it's they are sort of gray areas. It's not well defined as wrong and right. So maybe we don't want to engage into a debate with people. We can easily say, 'Well, I'd agree with you . . .' Who's right?" Because of lack of time: • "There are so many other things to learn about, things like documentation and confidentiality. Those are technical things that we maybe don't spend enough time emphasizing to the medical trainees." Because it's not valued: • "Maybe if we valued it. Maybe there should be an award for the staff that is the best model of professionalism." • "The dept really has no incentive to actually encourage professionalism on the part of its staff and faculty unless there are problems with resident education or inappropriate behavior from a research standpoint."

(Continues)

Table 2

(Continued)

Theme or subtheme	Example or quotation
Institutional and personal tolerance and silence	Faculty feel powerless to act: • "We recommended at the evaluation meeting that that person would not get a passing mark and that person graduated." • "I think we do not police ourselves and that's why, I mean this stuff will happen anyways, but I think we're not very good at putting an end to it when it happens. And I think we need to own that. And I'm as guilty as the next person. I grumble in the corners but don't do anything about it because I don't feel like I have enough power say or whatever." Disincentives exist: • "I think another reason is if you start pointing fingers you might be scared that people might start becoming more critical of you and start pointing fingers at everything you do wrong." • "I don't want to create a big conflict that will make our future working together more difficult than it is." • "I don't think I would feel skilled enough to make a correction, but if I felt strongly about it I would speak up about it." • "How do you interact with a colleague who is taking advantage of you? How do you work out conflict?… How do you deal with a staff person who has been horrible to you in a public setting . . . we never, ever, ever talk about it." Insufficient observations to make judgments: • "It's hard to monitor what your colleagues are saying to patients. I don't know who's going to have oversight over that. So again only the most egregious breaches rise to surface." Other: • "I think that sometimes the head of the department … the boss, it's their job to take this up. It's not my responsibility."
Stress	• "Highly stressful environment leads to people with less experience to decompensate and that just leads to breaches in professionalism." • "People's characters under stress lead to unprofessional behavior … certain stresses act in ways that they may or may not have insight into." • "I see it in the ICU quite frequently. If there's going to be problems they come to light typically in my experience in the ICU or operating room. Rarely do these things come to light just with daily ward activities."
Personality or character issues (individuals and mentors)	Insight and awareness of behavior: • "I think that a lot of the motivations for unprofessional behavior are actually unconscious. I don't think that most people who act in unprofessional ways think to themselves, 'I'm acting unprofessionally.'" • "Those people with the least amount of professional behavior . . . have the least amount of insight into their problem. So if you're trying to teach them they need to have to have insight. Hard to teach them that because they don't think they don't have insight." • "I think it can arise in a vacuum of modeling where they just don't get to see it. I think it can be quite inadvertent for some people; that they just don't know or they're not tuned in to the impact of their behaviors." Character deficiencies: • "The other I think is deficit. And the implication of deficit is it ain't fixable. There's a hole there. There's a hole there, can't be taught, can't be treated. And those people exist. They're the most painful ones to deal with." • "But there is a fourth group that are those that I think have an even more serious and dangerous disorder, which are the ones that are aware and they're not distressed, and they don't have deficit, but they do things because they feel can get away with it."

the hidden and informal curricula. As one participant put it,

> Virtually nothing is learned in lecture halls . . . it's about teachers and leaders modeling behavior, they [trainees] learn by observing. [Medicine] is still—no matter what technology we bring into teaching—an apprenticeship, and in the absence of modeling appropriate behavior, we can talk up the wazoo about professionalism, [but] it means nothing.
>
> ——Focus Group 5

Another participant referred to role modeling having both a positive and negative impact:

> If I'm having a patch where I'm feeling turned off and bitter and I'm making sarcastic comments, I notice that the housestaff team will pick up on that and they'll start behaving that way and it always sort of catches me up that I've got to turn this around or nobody's going to want to see us coming.
>
> ——Focus Group 1

Faculty felt that for education in this area to be relevant and meaningful for trainees, it needed to be integrated into the day-to-day fabric of their clinical lives. One faculty commented,

> I think it's one of those concepts everyone agrees is very important but when you are studying for your boards maybe you skip the seminar on professionalism . . . it somehow needs to be incorporated into the training experience so that it feels more immediate and salient.
>
> ——Focus Group 2

Self-reflection and nonjudgmental teaching environments were both identified as desirable. As one participant put it,

> What we don't do enough of is expose our own ignorance, our own vulnerabilities, and our own conflicts around these sorts of things which can open the doors for trainees to be talking about similar sorts of things.
>
> ——Focus Group 2

"Unprofessionalism" is a persistent problem

The final theme can be seen in a quote from Focus Group 5, where one participant noted, "I doubt that there's a single physician that hasn't been characterized by a patient, a colleague or [someone] as having behaved unprofessionally in a given circumstance."

In all of the focus groups, the most heated discussions centered on the third thematic category—the persistence of "unprofessionalism"—and the reasons for this persistence. Minor to moderate lapses in professionalism were perceived as widespread among faculty and trainees. One participant in Focus Group 3 went so far as to say, "I've experienced a lot of issues related to poor professionalism on the part of the residents . . . . I am constantly disappointed because of professionalism issues."

Specific examples given of these types of lapses on the part of both trainees and faculty were failing to change voicemail to alert patients and colleagues to absences, constant lateness, failure to arrange coverage for absences, issues related to appropriate dress, lying about holiday time, lying about work that has been done or not done, making negative comments in front of students regarding colleagues or patients, trainees refusing to see patients referred from the emergency room, financial conflicts of interest for faculty related to relationships with the pharmaceutical industry, and the use of medical interventions for financial gain rather than as a response to clinical indications. The majority of such lapses were perceived to be related to stress, inexperience, poor role modeling, and institutional tolerance; that is, they involved otherwise "good" people in difficult situations where the explicit and implicit rules for behavior did not always cohere.

Four major subthemes emerged that faculty identified as explanatory regarding the persistence of unprofessionalism. These were the fact that professionalism is not taught; institutional and personal tolerance and silence regarding unprofessionalism; stress; and individual lack of insight and character deficits (Table 2).

Faculty members' perception that professionalism itself is not well taught derived from their identification of difficulties related to its definition and from lack of time given to it in the curriculum and in faculty members' clinical teaching allotments for teaching and discussion of both professionalism and "unprofessionalism," as well as from faculty members' sense that their departments and educational institutions

did not truly value professionalism, let alone its teaching. As one participant stated,

> We aren't evaluated as faculty and kept on as faculty because of our professionalism. I know several faculty members that come to mind who are valued for their publications and contributions who are distinctly unprofessional. And everyone recognizes it, but it's okay because they've done all these other things.
>
> ——Focus Group 3

Participants identified a second explanatory theme as perceived institutional and faculty tolerance of and silence regarding unprofessional attitudes and behaviors among faculty, resulting in poor role modeling for trainees. Faculty identified several potential reasons for this tolerance and silence, including their own perceived lack of power within their institutions, disincentives such as time, paperwork, and fears of repercussion, inadequate feedback skills on their own part, lack of a remediation and support network once unprofessional behavior was identified, and, finally, lack of confidence in their own judgment. The theme of faculty feeling powerless arose in every focus group and was particularly discouraging for the participants. As one expressed it,

> If there is a really extreme example then it would probably be identified, although maybe not. But there are lots of kind of borderline things that are happening from day to day and nobody feels that they are in the position of strength to say, "What you just did was wrong, and let me tell you why and how you're going to improve that."
>
> ——Focus Group 1

Faculty identified stress as the third contributing factor to physician unprofessionalism. As one participant put it,

> I think [when good residents have unprofessional behavior] they're often acting out, because they are stressed and they're just under too much pressure.
>
> ——Focus Group 1

Faculty pointed to certain environments as likely to elicit stress and its perceived corollary of greater vulnerability to professional lapses, such as the operating room, the emergency room, and being on call. Participants also reflected on the impact of relative inexperience as well as

environment on the relationship between stress and unprofessionalism:

> I think that a lot of us could manage our emotions and manage our interactions with others when there are no distractions. We can focus on just being polite and just managing. But as soon as there's some additional stressor, the ability to do that drops off significantly.
>
> ——Focus Group 3

The fourth theme explaining the persistence of a different type of unprofessionalism, consisting of major lapses, related to an individual trainee or faculty member's character deficits. In all five focus groups, participants distinguished between two types of professionalism problems: minor unprofessional behaviors that are harder to define but are potentially remediable versus behaviors that are easy to define as unprofessional but are more likely to be irremediable. One participant stated,

> It's easy to identify the egregious unprofessional behavior. It's the more subtle ones that [are] . . . more difficult to get a handle on.
>
> ——Focus Group 3

Participants saw these egregious or criminal behaviors as rare, easily recognizable, but not easily remediable. They were largely perceived as characterological issues rather than related to discrete lapses in professional judgment. Interestingly, because of their rarity, ease of recognition, and the fact that there are systems in place for dealing with such lapses, most participants were not unduly troubled at the prospect of addressing them in their own practice and teaching.

Discussion

To our knowledge, our study is unique in its content and adds importantly to the field of medical education as it is a descriptive analysis of faculty members' beliefs about teaching and evaluating professionalism. The study has several methodological strengths. Although there were only 14 participants, they constituted five separate focus groups, consisting of representation from diverse clinical departments, and our dataset consisted of 188 pages of textual material for analysis. Qualitative interviewing methods lend themselves to smaller sampling opportunities given the depth of questioning they permit, and, indeed, our

major themes were consistent across all focus groups, suggesting theoretical saturation. Although the majority of our participants were specialists, they are all involved in teaching at both the undergraduate level (i.e., involved with a generalized approach to medical education) and at the postgraduate level. Moreover, many of them described a specific interest in education related to professionalism, which may challenge the perception that this topic is of interest primarily to primary care physicians.

We conducted the classic qualitative method of focus groups as it has been described by others,[43,46] and, using this method, we were able to achieve saturation of themes and ideas. Descriptive validity and the readers' experience of the study population's language and perspective were preserved by presenting direct quotes (lowest inference descriptors) from transcripts. This decreases the risk that we have imposed our own interpretation of participants' comments on the reader. Interpretative validity was optimized and researcher bias was minimized by negative case sampling, a method in which investigators purposefully and iteratively search for findings discordant with expectations and the developing theoretical framework.[46]

Our results are informative for those interested in faculty development in this area, both in terms of what faculty believe may be useful and feasible initiatives, particularly with regard to the need for more static and practical definitions for professional behavior, and also with regard to the limits that faculty development can achieve in environments where faculty see themselves as powerless in the face of professional, departmental, and institutional apathy.

Faculty expressed themselves as thirsty for an approach to defining professionalism that encompasses its nonstatic nature. That approach should acknowledge the conflicts that can emerge between what individual patients want from a physician and what "society" wants, a gap supported by a recent study by Boudreau et al[47]; it should also acknowledge the conflicts that can occur between definitions from different groups of physicians

based on their specific relationship networks and their clinical and financial contexts.[48]

Institutional failures both to recognize exemplary professionalism and to confront unprofessional behaviors were consistently seen as undermining faculty efforts. Perhaps more important, all groups identified that faculty members' own lapses in professionalism and their failure to address these with one another posed the greatest barrier to teaching professionalism to trainees, given a perceived dominance of role modeling as its most influential teaching tool. From this perspective, faculty defined themselves and their colleagues as teaching faculty members' own worst enemies.

It is surprising that a group of academic physicians—respected by their patients, trainees, and colleagues for their participation in teaching and research at one of Canada's premier medical faculties—view themselves as powerless to confront colleagues whom they perceive to be behaving unprofessionally. Given the existing literature on the importance of retaining and promoting clinician educators in addition to clinician researchers in our academic medical centers[49,50] and the high risk to faculty retention posed by a lack of communication with institutional leaders or an effective voice in governance,[51] our findings are both informative and a source for concern.

This research supports a perception among faculty that the professional and educational culture has failed to provide our clinician teachers and educators with clear, practical approaches to articulating standards for professional behavior in the face of multiple perspectives and interpretations. Faculty identify that this multiplicity of definitions can result not only in conflicts of values but in conflicts between definitions. In addition, faculty see a lack of concrete institutional supports that would facilitate their own adherence to, as well as their teaching and evaluation of, professional behavior, however defined.

As a result of these failures, faculty perceive themselves and their colleagues as colluding to create a culture in medical education of permissiveness and nonconfrontation around minor to moderate lapses in professionalism. This

culture, if not addressed, will result in a larger failure to educate and inspire future generations of physicians to support one another in collaborative reflection and the amelioration of their own and others' inevitable lapses in professionalism. Such a failure, in turn, will serve as a barrier to the open, nonblaming culture seen as necessary for rigorous investigation of the causes of medical error.[52,53] If minor to moderate lapses in professionalism are either covered up or treated as solely the province of the profession's outliers, the corollary is that their probable impact on team function, delivery of patient care, and patient safety will not be explored or addressed.

Our study has several limitations. First, it was conducted at a single center located in an urban, academic setting, so the findings may not be fully generalizable across all cultural and socioeconomic communities. Second, the focus-group facilitators were known to the study participants, which may have introduced bias; however, given the richness and honesty of the discourse, we feel that participants felt unencumbered to discuss issues freely, including those of a personal or sensitive nature. Third, as noted, recruitment for the study was difficult, ostensibly because of geography and scheduling conflicts, and the number of participants was lower than we had initially anticipated. It is therefore possible that our participants represent a minority of medical teachers who do ascribe primary importance to this area. The overrepresentation of female clinical teachers, particularly from surgery, in our focus groups also raises interesting questions regarding women faculty members' specific interest in professionalism.

In conclusion, our research supports the recommendation that any faculty development interventions that hope to change our current culture of teaching and evaluating professionalism will need to promote greater identification, discussion, and remediation of our own, our colleagues', and our trainees' minor to moderate lapses in professionalism. Such interventions will require a collegial, supportive, and open environment that promotes both self- and group reflections on these complex and difficult matters.[40] In addition, such interventions will need to engage faculty in identifying the

societal, professional, and institutional cultures in which they and their learners train and practice, and the influence of these cultures on our definitions of professionalism.

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The Hidden Curriculum: What Can We Learn From Third-Year Medical Student Narrative Reflections?

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Abstract

Purpose
To probe medical students' narrative essays as a rich source of data on the hidden curriculum, a powerful influence shaping the values, roles, and identity of medical trainees.

Method
In 2008, the authors used grounded theory to conduct a thematic analysis of third-year Harvard Medical School students' reflection papers on the hidden curriculum.

Results
Four overarching concepts were apparent in almost all of the papers: medicine as culture (with distinct subcultures, rules, vocabulary, and customs); the importance of haphazard interactions to learning; role modeling; and the tension between real medicine and prior idealized notions. The authors identified nine discrete "core themes" and coded each paper with up to four core themes based on predominant content. Of the 30 students (91% of essay writers, 20% of class) who consented to the study, 50% focused on power–hierarchy issues in training and patient care; 30% described patient dehumanization; 27%, respectively, detailed some "hidden assessment" of their performance, discussed the suppression of normal emotional responses, mentioned struggling with the limits of medicine, and recognized personal emerging accountability in their medical training; 23% wrote about the elusive search for personal/professional balance and contemplated the sense of "faking it" as a young doctor; and 20% relayed experiences derived from the positive power of human connection.

Conclusions
Students' reflections on the hidden curriculum are a rich resource for gaining a deeper understanding of how the hidden curriculum shapes medical trainees. Ultimately, medical educators may use these results to inform, revise, and humanize clinical medical education.

> Not all of what is taught during medical training is captured in course catalogs, class syllabi, lecture, notes and handouts…. Indeed, a great deal of what is taught—and most of what is learned— in medical school takes place not within formal course offerings but within medicine's "hidden curriculum."
>
> —Frederic Hafferty, PhD (1998)

Since the 1960s, educators have described the power of a "hidden curriculum" in shaping the values and behaviors of learners, a concept initially introduced to the medical education community by Frederic Hafferty.[1] Inconsistent— even dissonant—teaching from formal and implicit curricula creates tension for young doctors in the process of forging a sense of professional identity.[2] In our work, we use the term "hidden curriculum" to refer to learning that occurs by means of informal interactions among students, faculty, and others and/or learning that occurs through organizational, structural, and cultural influences intrinsic to training institutions. The curriculum we seek to understand is buried in the lived experiences of learners. Understanding how learners experience and engage the hidden curriculum is fundamental to the work of medical education.[3]

Medical educators, socialized themselves by the hidden curriculum, may not be able to fully see and hear beliefs, values, and implicit codes of behavior as they pass these on to the next generation; however, third-year medical students are uniquely positioned to observe the hidden curriculum. They are liminal operators—simultaneously both outsiders and insiders to medical culture. Students are an accepted part of the medical team. They dress the part and speak the language of medicine, yet they bring beginners' minds and thus can observe and name cultural phenomena that become invisible to doctors over time.

Many have used anthropologic inquiry to describe the hidden curriculum in medical education.[4–6] Several themes recur in these descriptions: the loss of idealism, the prominence of hierarchy, the adoption of a ritualized professional identity, and emotional neutralization. In attempts to further characterize the hidden curriculum, researchers and medical educators have employed a variety of empiric methods, including tape recordings of medical students and residents talking to one another informally about work[7]; student reports of ethical dilemmas[3,8–10]; focus groups of senior medical students discussing perceived lapses in professionalism[11]; and semistructured, one-on-one interviews to characterize the teacher–student relationship and its significance in the hidden curriculum.[12] Paul Haidet and colleagues[13] have even developed a

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validated survey instrument to assess the degree of patient-centeredness in the hidden curriculum of a medical school.

Student narrative essays provide a rich source of information about the hidden curriculum. Routinely assigned to encourage reflection and to support the professional development of medical trainees,[14,15] narrative essays are underused as a source of data[16] for curricular reform. Student essays provide both a useful window into the educational experience of learners and a potential substrate for faculty development and curricular enhancement.[17] We hypothesized that student narratives on the hidden curriculum would identify positive curricular elements that curriculum designers could emphasize and negative elements that they could target for reform. We anticipated that analysis of these student narratives could provide not only insight into the cultural norms embedded in the hidden curriculum but also more subtle observations about the complex ways in which our learners understand and interact with it. We aimed to examine the hidden curriculum through students' eyes and to consider the implications for medical education and the training of future physicians.

Method

Third-year students at Harvard Medical School are required to write three reflection papers as part of a longitudinal patient–doctor course.[18] The yearlong course is taught in multiple small groups of approximately 10 to 12 students. We assigned the students in three such groups, selected to represent students doing clinical clerkships at a diverse range of teaching hospitals, to write one of their reflection papers on the topic of the hidden curriculum (Box 1).

The Harvard Medical School institutional review board determined the study to be exempt.

We deidentified the reflections and analyzed them using qualitative grounded theory in an iterative coding process described by Strauss and Corbin.[19] Three of us (E.G., S.B., M.B.) read the papers independently and identified concepts in a process of open coding, and then we used the constant

comparative method both to describe concepts and to group these concepts within themes. We completed multiple cycles of coding and discussion to clarify, refine, and rename themes until we fully described and categorized all the data within the narrative reflections. We ultimately identified nine core themes that illuminated a discrete aspect of student experience of the hidden curriculum. We created a coding manual which named and defined each core theme. Each of the three reviewers then independently coded all narratives, found only minor discrepancies, and revised the coding manual to reflect consensus-based definitions. To help ensure the trustworthiness of our analysis, we invited a fourth independent physician reviewer (R.S.) to code each narrative. Coding agreement between the independent reviewer and the original team was >95%. We ultimately coded each reflection with one to four of the nine core themes. In addition to the nine core themes, we identified several overarching concepts that were implicitly present in virtually every student narrative and seemed to function as operational definitions of the hidden curriculum (see Results). To further corroborate the trustworthiness of our analysis, we presented the themes for a "member check" to seven study participants (23%) who then confirmed that the themes resonated with their experiences.

Results

Thirty-three students (100%) in the three groups completed the assignment. Of these, 30 students (91%) consented to the

study, representing roughly 20% of the entire third-year class.

Four defining concepts

Four overarching concepts appeared in some way in virtually every student reflection:

1. Medicine as culture,
2. Haphazard interactions,
3. Role modeling, and
4. Tension between the reality of clinical medicine and previously held idealized notions, including those acquired from formal curricular teachings.

These four concepts were so implicitly and pervasively present as to serve as definitional elements of the concept of the hidden curriculum.

Medicine as culture. First, students were quick to recognize that clinical medicine *is* a culture with distinct subcultures. Their notion of culture seemed consistent with classic anthropologic notions of a group of people who share a set of common values, beliefs, vocabulary, and behavioral norms. They noted that ingrained and sometimes idiosyncratic customs govern interactions among the health care team, and many focused their efforts on trying to decipher the unspoken rules of teaching hospitals. One student devoted her paper to the rules governing the ubiquitous phenomenon of "complaint":

> Patients in physical pain should complain no more frequently than approximately once an hour. Expression of pain should be limited to several acceptable formats, including strained but stoic requests for pain medications, direct response to queries about severity on the 1/10 pain

The "hidden curriculum" is the set of influences on one's development as a physician that is not explicitly taught. It is transmitted through interpersonal interactions on the wards or in other clinical settings, through positive or negative role model behaviors, and through the culture and hierarchy of medicine. Examples of what might be imparted through the hidden curriculum include implicit "rules to survive" at a particular institution, the accepted manner of interacting with patients or colleagues, attitudes toward and treatment of difficult or marginalized patients, choices about personal/professional balance, and ways of coping with suffering/loss/death. The hidden curriculum influences the values, roles, and identity a physician develops over the course of training. The hidden curriculum is a strong socializing force, and its influence can be positive, negative, or mixed.

Please write a two-page paper reflecting on the hidden curriculum as you have observed it during your clerkship experience. We suggest that you start out with a personal anecdote or story that epitomizes some aspect of the hidden curriculum and use this anecdote as a starting-off point for your reflection.

scale that never exceed 9/10….
Physicians, however, may never, under
any circumstances, complain about the
number of hours they work. To do so
would be an egregious expression of a
lack of commitment to the profession.
While this rule applies to all physicians,
lapses in adherence to it are particularly
frowned upon in young doctors and
female doctors. [Physicians] are
encouraged to complain about insurance
companies' lack of appropriate
reimbursement for any aspect of patient
care and may complain about their
patients, especially patients who keep
returning with unmet needs.

Haphazard interactions. Students also
described learning what they need to
know through haphazard interactions
and random events—that is, arbitrary
team and patient assignments, chance or
informal encounters, fortunate or
unfortunate accidents.

> I don't blame the resident. How could he
> know that he would show up Sunday at 6
> AM and have "ushering a naïve medical
> student through death and dying" [as]
> part of his 28-hour shift?

> After three years of discussing the ethics
> of abortion, I saw three in one day during
> my ob/gyn rotation. Nobody planned it
> that way. It just happened.

> My most profound lesson of compassion
> was given over a plain bagel with onion
> and chive cream cheese and a medium
> cup of coffee.

Role modeling. Students recognized the
powerful influence of positive and
negative role models on their learning.

> [T]he fact that this doctor cared so much
> for his patients that he would visit them
> on a weekend before an out-of-town trip
> was the most surprising part of this
> experience. Maybe it was less of a surprise
> or shock and more of an awestruck
> admiration that comes when you find a
> role model in your future career—
> someone you want to be like when you
> "grow up" to be a doctor.

Medicine as ideal vs. medicine as reality.
Finally, students routinely recognize
tension or misalignment between their
prior idealized notions of medical
practice, as often conveyed through the
formal curriculum, and their actual
experiences in clinical training:

> I always thought my first time would be
> different. I took extra time through first
> and second year to hear about what it was
> like to have dying patients, going to
> seminars, hearing from professors, even

researching music in palliative care. But
when a 42-year-old man with terminal
Gardner syndrome was admitted to my
surgery team, I followed everyone else's
lead and avoided him.

Core themes

Nine core themes characterized discrete
elements of the hidden curriculum. Of
the 30 students who consented to the
study, 15 (50%) focused on
power–hierarchy issues in training and
patient care; 9 (30%) described patient
dehumanization; 8 (27%), respectively,
detailed some "hidden assessment" of
their performance, discussed the
suppression of normal emotional
responses, mentioned struggling with the
limits of medicine, and recognized
personal emerging accountability in their
medical training; 7 (23%) wrote about
the elusive search for personal/professional
balance and contemplated the sense of
"faking it" as a young doctor; and 6 (20%)
relayed experiences derived from the
positive power of human connection.

1. Power and hierarchy. Half of the
students' reflections focused on use and
abuse of power in the hierarchy of
medical training and health care.
Students highlighted the effects of
abusing hierarchy on two sets of
subordinate–superordinate relationships:
student–teacher and patient–doctor.
Medical students described feeling
disempowered and disrespected; they
identified intense pressure to "know their
place" in the medical hierarchy and
endorse the dominant culture.

> Almost everyone in the room smirked,
> knowing this attending was not using his
> best clinical judgment; however, no one
> said a word to him because of his rank as
> an attending…. Because of the
> hierarchical structure of academic
> medicine, it is often assumed that the
> person at the top of the chain has the
> most knowledge and is, in essence,
> untouchable.

Several suggested that patients, too, felt
pressure or were otherwise inclined to
unquestioningly accept physician
authority.

> I had found myself indignant that the
> residents had selected him [a particularly
> vulnerable patient] to be part of bedside
> rounds…. I feared that he had consented
> more out of obligation than desire, and I
> was concerned that it would hurt his
> already wounded heart to be examined so
> sterilely.

Some students, while naming their own
powerlessness within the hospital
hierarchy, also recognized the power they
held over patients. They lamented the
need to practice clinical skills on patients
who were pragmatically powerless to
refuse.

> I am standing before an anxious, supine
> woman, holding a gleaming large metallic
> object that I am about to place into her
> vagina. Right now only two things stand
> between me and an unpleasant encounter
> with law enforcement. One is the
> remarkable prerogative bestowed upon
> medical professionals to do such strange
> things. The other is my patient's half-
> hearted consent. "You're letting the
> novice do it?" the patient groans to my
> intern. "I've done a couple of these
> already," I offer her in the way of feeble
> reassurance. But really, I can only
> sympathize with her—I wouldn't want
> me doing my pelvic exam either.

2. Patient dehumanization. Students
observed patients disrespected, coerced,
and dehumanized in the day-to-day
practice of medicine. One student
described a neurology "patient rounds"
conference at a tertiary care teaching
hospital:

> It was during the physical exam that I
> became most uneasy because I usually
> had no idea what the attending was going
> to say or do next. There were several
> times when a patient was called
> "demented" or "frontal" without having
> any explanation given to them…. The
> most horrific thing I saw was when the
> attending asked the patient to turn over
> and then proceeded to demonstrate the
> anal wink reflex to us without warning
> the patient of what he was going to do.

Students saw patients stripped of their
uniqueness (stories, personality, culture)
in service to "objectivity":

> It's like I just took all those real human
> feelings … and I crammed them,
> reorganized them, and dehydrated them
> to fit in a succinct little box. "This patient
> fits into this rubric." I get angry just
> thinking about it.

3. Hidden assessment. Students
described feeling "under the microscope"
and expending significant energy
discerning the elusive criteria by which
their clinical instructors evaluated them.
Students felt their superiors judged or
evaluated them on unnamed criteria in
addition to— or instead of—the explicitly
stated criteria for evaluation. One student
described the "opportunity to learn"
during a bronchoscopy:

As I continued to struggle with positioning of the camera, he laughed and said, "Whoa, somebody has a short attention span … did you listen to my directions on how to work this thing?"… "Are you having a seizure?" he asked at one point, as I struggled to center the camera. "No," I said in the most confident voice I could muster. I didn't want to give him any pleasure out of his joke. He got some anyway. The second-year resident burst out laughing.

Ultimately, the student received plaudits on the good job he had done. He concluded,

What a bizarre experience. I felt like a complete failure while harassed throughout the procedure. Contrast that to the near high I felt after I was congratulated at the end…. I felt as if I had survived some kind of psychological test. I now know that it really didn't matter what I did with the scope. It was more important that I didn't fold under the criticism, and that I didn't quit.

Attributions of success or failure by superiors may have little to do with how well a student learns clinical skills or medical knowledge; rather they may reflect acquiescence or assimilation to the culture of the particular rotation. Fear of a negative evaluation may even compel students to suppress medical knowledge or avoid advocating their own safety. One student wrote with anger about the impact of implicit assessment criteria on the student's own learning:

Do I know not to challenge a surgeon about using disproved regimens or prescribing aminoglycosides for a single post-op fever? Do I know not to make a fuss about needle sticks, especially when there's no postexposure prophylaxis? Do I know how to appropriately raise my concern that our chosen surgical technique risks seeding a tumor and how to keep quiet when these literature-supported concerns are rejected so that the wrong procedure can be undertaken simply because that's what the surgeon wants to do? Absolutely.

4. Emotional suppression. Some students' reflections described the need to actively suppress emotions in response to the powerful experiences of hospital life; other students wrote of distracting or disassociating oneself from "normal" emotional responses to suffering and death, and still other students wondered about their own *lack* of emotions. One student recalled observing an abortion, during which the attending physician and the nurses were behaving "as if nothing

had happened." She wrote an ode to the aborted fetus:

We dump you into a pan to weigh our prize

Rubbing our hands together, greedy,

Count your limp appendages, record them in a ledger

Our backs turned to the emptied mother.

Another describes his first pronouncement on a busy call night:

How could I spend hours in my first two years discussing imagined deaths, wondering about the scale of life and life's end, only to see a patient die and have it feel like one more box on a to-do list?

5. The limits of medicine. Students frequently grappled with the uncertain role of the doctor in dealing with the nonmedical dimensions of patient well-being. They pondered the limits of medicine in addressing the human condition— existential states of suffering and social deprivation. They lamented the inadequate focus on prevention. Students seemed to be asking, "How broadly are we supposed to define our role as healers?" and "How do I reconcile the 'drop-in-the-bucket' effect of my limited interventions?"

One student who made a home visit to an elderly patient pondered,

It is not the wet stench of cat urine, not the pitiful sight of dust and grime and garbage, not the meanness of the metallic throne upon which my patient slumps— it is the powerful weight of loneliness that fills me with despair. Today's home visit does not feel like a medical exercise, and I have no desire to go through the checklist of health concerns in the thick patient file that sits listlessly in my bag. True, my patient has a long laundry list of scary health problems, and she deserves counseling about lifestyle modifications and the importance of medication compliance in order to decrease her risk of developing a myriad of future complications. But all of these things strike me as ridiculous in the moment. My patient's problem list, in my opinion, consists of a single item heading: the unimaginable suffering of isolation.

Another wrote,

Throughout the past five months I've been struck so much more than I could have ever imagined by the reality of the inequities that exist. How can we talk about bootstraps when some people's boots are made of sand, and crumble with a glance, let alone a tug?

6. Emerging accountability. Reflections highlighting students' growing awareness of their duties to their patients and their own learning focused on the importance of personal responsibility and self-direction in the training process. Students recognized the need to actively seek out medical education rather than "letting it happen to you." They described an emerging sense that the student must sculpt professional virtues, values, choices, and behaviors for him- or herself.

I spent a good part of the beginning of this educational sojourn waiting for someone to clue me in on how I would best be able to learn the things that I needed to. The advice never came … what changed was me. The month of November was an awakening to the fact that the learning was only going to come if I sought it out myself.

7. Balance and sacrifice. Several reflections focused on the elusive quest for personal/professional balance across the trajectory of medical training; often, medicine received priority over even basic human needs and safety. One student writing her paper while home on maternity leave described two fundamental roles in conflict:

My friends who have already had children and pumped [breast milk] while working their nonmedical jobs have heard my description of the clerkships and advised early weaning as my only option. It would be sad if working in the medical profession kept me from doing the medically recommended thing for my kid.

The difficulty in managing such priorities is even more difficult when role models are unable to achieve balance themselves:

One preceptor had been complaining about not having the time to go to important doctors' appointments with her elderly mother. I had actually misheard her and thought she was unable to go to her own doctor's appointment— "Ha!" she said, "Take care of myself? I definitely don't have time for that!"

Students observed a culture that at times seemed to expect sacrifices approaching martyrdom:

I'd been working to quell sharp reactions, the too rapid movement of my hand to catch a falling instrument or the too quick jerk of my head to avoid blood from a pumping artery…. The flying needle was the first of dozens…. [After a] flying needle driver bounced off my knuckles …

I glanced around, and then slowly drew my hand to surreptitiously examine my right thumb where the needle had poked me. I rubbed the spot. Yes, there was blood underneath the glove.

8. "Faking it." Many reflections indicated awareness of the need to first "act" like a doctor and/or expressed variable degrees of confidence that the doctor role would eventually be internalized. Students who described "faking it" implied a theatrical quality to the medical training experience involving the use of scripts, costumes, and other props— often juxtaposed with authenticity. One student discussed her relationship to her white coat:

> I felt vaguely like a child "playing dress-up," and frequently wondered whether patients could see through the cheap costume in order to scrutinize my actual competency. Still, I clung to the white coat as an official uniform, perhaps as proof to reassure both myself and the patient I belonged in the room, that I had the capability to assume responsibility for the lives of patients (who often appeared much older and wiser than I). Even now, the white coat still offers me a sense of validity, of entitlement. It is essentially a façade, but I confess with a visceral twinge of chagrin that it heightens my confidence in my abilities to perform.

9. Human connection. Several reflections described the importance of authentic human connection for both patient healing and student learning. Such connections may be between peers, between students and teachers, or between clinicians and patients. After a preceptor shared with a student something of his own personal struggle, the student wrote,

> There is a Hebrew term, Talmid Haver, which means "a student who is a friend and colleague." By disclosing something personal and important, Dr. T was able to help me to feel like a colleague, an equal who could problem solve with him and listen to his problems. As I felt more like an equal, it was—notably—easier to admit what I didn't know and to ask for help, to be a conscientious student.

Another student made a conscious choice to focus her reflections on the positive aspects of human connection, the potential for caring. She wrote,

> I could hold a grudge against the resident [who] once lamented, "Why can't they go die somewhere else?" or another who, after smiling widely at a patient, nonchalantly shrugged out of earshot, "He'll be dead in six months." I could

find endless inhumanities in my hospital experiences—things that would make me sad and frustrated, every day. But it would be short-sighted to say that this is all that I have seen worth noting.

She went on to recount a precious moment in which she surreptitiously observed one of her peers return to a dying patient's bedside to engage him in conversation:

> It is lovely to watch someone get it right. And it is appropriate that I could learn that lesson best from a peer, one with no more or less knowledge of medicine than me, but with endless humanity he was willing to share.

Internal transformation: Students as active learners within the hidden curriculum

In the experiences they recounted, students emerged as active agents in their own learning. Their candid sharing of emotional reactions and interpretive reflections allowed us to begin the work of understanding how external influences shape students' internal transformations. As important as the socializing forces that acted on them were the active decisions students made in adopting or rejecting messages they internalized from the hidden curriculum. Some wrote with anger and explicit resistance to the values they saw espoused in the hospital. Others noted their own developing respect for the culture they observed:

> While I was taken aback at first, I've slowly begun to realize that the "surgical persona" donned by some needs to be examined in the full light of the profession and the surgeon's role in patient care…. Distancing oneself from the situation seems to be the best way to achieve proper judgment at times, allowing one to appropriately and courageously minister to the needs of the patient.

The occasional student was able to embrace paradox and acknowledge simultaneous resistance to and resonance with the culture.

> I tell my chief that Ms. Kelly is doing all right…. "The whale?" she asks. I pause for a millisecond, feeling trapped between righteousness of confrontation and the ease of assent. I'd rather fit in than make a scene. "Yes," I say. It would be easier if things were black-and-white, if I could loathe them for calling the obese patients on our service heffalumps, whales, and porpoises. But the truth is far more gray, and my team's harsh comments are

accompanied by an obvious commitment to their patients.

Many reflections revealed students making their own meaning of events and articulating their own resolve. After telling a story about discomfort with the need to feign confidence in order to win trust, one student pragmatically articulated his own belief:

> Frankly stating when one has reached the limit of one's knowledge … is good practice both ethically and intellectually. A similar policy might be followed by medical students—when the duties assigned seem inappropriate to one's level of training or knowledge, the student should share this feeling with superiors, who can then reevaluate the assignment or offer encouragement.

Feeling emotionally spent after long days on a pediatrics rotation, one student opined,

> I think the onus is now on me to find what recharges me…. It is true that the two feed-forward on each other—the more happy I am outside the hospital, the happier I am at the hospital, which makes me even happier outside. I think the key is to stay mindful of this cycle, knowing that it can flow positively and negatively. Finding a renewable energy source is important to maintaining a rewarding career in medicine, as coffee and candy can only get one so far.

Discussion and Conclusions

Recent work has advocated examination of student critical incident reports[15] and narratives on professionalism to gain new information about the hidden curriculum[16]; our study takes the next step by explicitly asking students to write about the hidden curriculum. Our discovery within the narratives of four overarching and pervasive concepts—medicine as culture, haphazard interactions, role modeling, and tension between "ideal" and "real" medicine—aligns with the concept of the hidden curriculum as commonly described in the literature, and affirms that our students understood the prompt and assignment.

Our thematic analysis of student reflections provides a window into our students' lived experiences and adds to the existing literature by offering three novel aspects: (1) richly detailed and nuanced descriptions of the hidden curriculum by liminally positioned participant–observers, (2) insight into

the external influences that students encounter as well as the diverse ways they engage those influences in the process of internal transformation, and (3) a framework to guide curriculum reform directly informed by student experience.

Student lessons from the hidden curriculum

We were struck by the pervasive moral challenges described in student reflections. Many reflections recounted critical decision points about assimilating to the dominant culture or holding fast to personal and professional values in conflict. Such "microethical" challenges—taking short cuts, acknowledging mistakes, engaging bias—are ever present for trainees on the wards and in clinics.[8,20] As others have noted, the list of real-world ethical dilemmas that students face every day does not correlate well with topics on the syllabi of most traditional ethics courses.[11] Our student vignettes resonate with Feudtner and colleagues'[21] findings that 40% of third- and fourth-year medical students reported doing something wrong or improper for fear of poor evaluation or in an effort to "fit in" with the team.

Such challenges are further confounded by power and hierarchy, the most prevalent theme in our analysis. Several reflections illustrating hierarchical relations of power also illustrated dehumanization of patients and hidden assessment of learners, underscoring Brainard and Brislen's[3] assertion that power and hierarchy may serve to maintain and reinforce *un*professional behavior. Those at the top of the hierarchy have the dual privilege of defining "professionalism" and evaluating students on the basis of these definitions. All too often, student "professionalism" is simply equated with subservience within the hierarchy. Specific efforts to evaluate professionalism merit further attention. Roughly half of U.S. medical schools have explicit methods to assess professionalism, and only about a third conduct specific faculty development sessions in this arena,[22] a reality echoed in students' views on hidden assessment and subpar role models.

The hierarchical nature of medical culture has frequently been compared to the military. But unlike the military, these student narratives underscore that expected behaviors in medicine are rarely made explicit, and accountability of superiors is not always defined. The unwritten rules of engagement make medical recruits' ability to understand and excel in their environment difficult. Students' focused attention on decoding expectations, rules of conduct, and rotation-specific behavioral nuances may come at the opportunity cost of time otherwise spent on learning medicine and patient care.

Other maladaptive aspects of medical culture include emotional suppression[23,24]—as our students' reflections poignantly express. The rapid pace at which medical practice moves, combined with the sheer magnitude of human suffering, can be overwhelming. Though suppression of emotion is a pragmatic short-term survival strategy, the long-term consequences—for doctors, for patients, and for the wider health care system—are potentially grave. Multiple studies demonstrate the erosion of empathy over the course of medical training[25,26]; possibly, distancing from self leads to distancing from patients. Equally concerning are recent data suggesting that it may not be the traumatic clinical content of medicine but, rather, student mistreatment and poor role modeling that lead to depression, anxiety, and lack of psychological well-being among medical students.[27]

As important as the themes we encountered are those we did not. Perhaps the even more challenging aspects of the hidden curriculum are those that lurk below the surface of detection, those influences that students

Table 1

Themes From the Hidden Curriculum Derived From Third-Year Harvard Medical School Students' Narrative Reflections Linked to Curricular "Solutions," 2008

Core theme	Solution
Power/hierarchy	Emphasize multidisciplinary teamwork and thoughtfully define meaningful roles for all team members, including students. Develop mechanisms of accountability within hierarchical relationships, particularly pertaining to professionalism.
Patient dehumanization	Incorporate patient voices as often as possible into medical education. Make bedside rounds. Design patient-centered educational experiences for students.
Hidden assessment	Be transparent about expectations and methods of evaluation. Develop routine and legitimate ways to support students who find their own values and learning goals to be in conflict with hidden curricular pressures.
Emotional suppression	Foster safe havens where students can reflect on (rather than suppress) their experiences and mature in their ability to engage the emotional work of doctoring.
Limits of medicine	Review the formal curricular offerings and consider the messages that are communicated about what *is* and what is *not* within the scope of the doctor's concern. Periodically review work rounds and hold precepting conversations with students to understand how patients' social and emotional needs are addressed. Make accessible physicians who are positive role models, who engage social justice and take on health system challenges.
Emerging accountability	Design educational experiences that expect, encourage, and reward independence, initiative, and self-determination.
Balance/sacrifice	Sponsor constructive and honest conversation among physicians at every stage in training about choices, consequences, and compromises in balancing personal and professional lives. Advocate benefits/rules that protect family life and personal time.
Faking it	Explicitly seek ways to calibrate student responsibilities in a gradual manner, and support students as they present themselves to patients. Help students mitigate the tension of playing new and unfamiliar roles. Ask about, and then help students negotiate, the "microethical" challenges of their day-to-day clinical experiences.
Human connection	Cultivate the conditions in medical institutions that are conducive to growing and nurturing longitudinal relationships. Organize work in small units; learn everyone's name; eat together; celebrate beginnings, endings, and transitions.

do not perceive and therefore did not name, or those that students recognize but do not feel comfortable discussing. For example, only one of our students mentioned the role and status of nurses or other nonphysician colleagues on the health care team. Only one student mentioned the impact of the device industry on medical practice. None wrote about politics or the pressure to get ahead by competing with peers.

External forces and internal transformations

In their reflections, many students identified their own active role as learners, metabolizing or rejecting the messages of the hidden curriculum. While the reflections convey the students' sense of powerlessness to effect change in the external (learning and patient care) environment, they actively struggle with choices: One student wrestles to keep his hands in the surgical field despite flying sharps; another grapples with ambivalence, recognizing that her team's behavior in caring for obese patients is at once loathsome and dedicated. Many students write with sophisticated insight regarding their chosen stance in the story they tell. From this lens—students as active learners in the hidden curriculum—we propose a paradigm shift. Students—indeed, each of us, independent of level of training—is not a passive victim but an active contributor to the hidden curriculum. Every time we make a choice—react or don't, repeat unprofessional behaviors or seek out more admirable ones—we are feeding something back into medical culture. Our collective actions and reactions create the culture in which we work and learn. Though limited by the hierarchical structure of medical education, students do have choices, and educators can help.

Curricular reform

By providing insight into what students are actually learning, these reflections offer guidance for curricular reform. First, this work reaffirms the power of student reflections to initiate a conversation about the hidden curriculum.[28] Explicitly asking students to be anthropologists of medical culture, as this assignment requires, may in itself help students cultivate a useful critical distance. We used excerpts from these papers to facilitate small-group conversations with medical students, thereby exposing "hidden" influences and permitting students to strategize together about ways of responding. Sharing these reflections up the hierarchy and allowing these student voices to speak to residents, faculty, and administrative leaders may also be critical components of meaningful change. Interestingly, the disconnect between espoused values and lived experience apparent in student papers is also described by senior physicians.[29] Attention to what is working well is as important as attention to what is not. Some medical educators have effectively used an "appreciative inquiry" approach,[30,31] that is, collecting, analyzing, and disseminating positive examples from the hidden curriculum to inspire cultural transformation in medical institutions.

Beyond simply exposing the hidden curriculum, we can work intentionally on remediating problematic dynamics. Each of the nine themes identified in our student narratives invites a response from medical educators (Table 1).

Limitations of our study include the small sample size from a single academic health center. Our students are likely affected by exposure to a common culture during the first two years of medical school, despite completing clinical rotations at many different hospitals. Although the hidden curriculum they describe may be different than the hidden curriculum at other schools, our findings resonate with other qualitative studies on the hidden curriculum.[4–6,11,12] Furthermore, we continued to discover these same nine themes (and no new themes) in informal review of dozens of hidden curriculum narratives written by subsequent groups of third-year medical students over the next two years.

As medical educators, we do well to listen to our students. Their reports of what they are learning reveal what we are actually teaching.

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Perspective: **Malpractice in an Academic Medical Center: A Frequently Overlooked Aspect of Professionalism Education**

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Abstract

Understanding how medical malpractice occurs and is resolved is important to improving patient safety and preserving the viability of a physician's career in academic medicine. Every physician is likely to be sued by a patient, and how the physician responds can change his or her professional life. However, the principles of medical malpractice are rarely taught or addressed during residency training. In fact, many faculty at academic medical centers know little about malpractice.

In this article, the authors propose that information about the inciting causes of malpractice claims and their resolution should be incorporated into residency professionalism curricula both to improve patient safety and to decrease physician anxiety about a crucial aspect of medicine that is not well understood. The authors provide information on national trends in malpractice litigation and residents' understanding of malpractice, then share the results of their in-depth

review of surgical malpractice claims filed during 2001–2008 against their academic medical center. The authors incorporated those data into an evidence-driven curriculum for residents, which they propose as a model for helping residents better understand the events that lead to malpractice litigation, as well as its process and prevention.

Every physician is likely to be sued by a patient, and how the physician responds to a lawsuit can change his or her professional life. Medical malpractice has a significant impact on patient safety and the manner in which physicians practice

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medicine, but even many faculty at academic medical centers know little about malpractice despite the attention paid by the media to escalating malpractice insurance rates and settlement payouts. Although the issue is important to physicians and patients alike, residency programs' professionalism curricula rarely cover the incidence of medical malpractice or behaviors to avoid it. Residents in training, therefore, have limited exposure to the principles of malpractice law and, as a result, have little understanding of how malpractice will affect their careers.

We believe that information about the inciting causes of malpractice claims and their resolution should be incorporated into education both to improve patient safety and to decrease physician anxiety about a crucial aspect of medicine that is not well understood. In this article, we highlight national trends in malpractice litigation and residents' understanding of malpractice, then share our research concerning malpractice claims at the NYU Langone Medical Center/Bellevue Hospital (NYU/Bellevue). Finally, we describe the malpractice seminar we developed for surgical residents using these data and propose that such an evidence-driven educational intervention for surgical resident learners can

significantly improve their understanding of the causes of malpractice and its resolution through the legal system.

National Trends in Malpractice Claims

Since 1975, medical liability costs have risen an average of 11.1% per year, outpacing increases in overall U.S. tort costs, which have risen an average of 8.4% annually.[1] Liability insurance rates for general surgeons, for example, reflect an average physician defense cost of more than $90,000 for a claim that goes to trial in which the surgeon prevails.[2] Median settlement payouts and jury awards are also growing. From 1997 to 2006, they increased from $100,000 to $204,500 and $157,000 to $487,500, respectively.[2]

Despite state and federal action, frivolous malpractice claims continue to contribute to this growth. The number of malpractice suits far exceeds the number of "true negligence" claims: As many as 37% of malpractice claims do not involve an error,[3] and as few as 1 in 35 cases of actual negligence results in a lawsuit.[4] It has been suggested that the majority of medical malpractice suits may not be driven by clinical quality of care but rather by other factors, such as the physician's level and manner of

communication with the patient,[5] the plaintiff's degree of disability,[6] and patients' lower levels of confidence in physicians due to negative experiences with managed care.[7]

A study of actual technical errors in surgical procedures—what surgeons would characterize as negligence—found that the majority were not committed by newer surgeons or experienced surgeons performing challenging procedures but rather by experienced surgeons doing routine procedures.[8] Thus, operating room procedures aimed at patient safety (e.g., marking the surgical site, confirming the operation and side of the body orally with the patient prior to anesthesia, the timeout) are most important for routine procedures. Residents need to understand that mistakes occur more frequently in simpler procedures, when their guard may be down.

Studies have shown that a significant proportion of residents commit medical errors during the course of their training and suffer considerable emotional distress as a result.[9] Residents coping with their mistakes have been shown to be encouraged by reassurance and the opportunity to learn from mistakes as facilitated by their training programs and faculty.[10] This suggests that residents may benefit from understanding how medical errors affect them personally and are handled by attendings in the context of their practice and the legal system.

Residents' Understanding of the Malpractice Process

Residents' lack of knowledge of the causes and resolution of malpractice actions in their roles as trainees has been highlighted by a number of studies. Singh et al[11] reviewed five insurance companies' databases for malpractice claims naming trainees from 1979 to 2001. Among the 240 claims they identified, remarkably 70% were due to "teamwork failures," such as hand-off problems/miscommunications and lack of supervision by more senior residents or attendings. Rodriguez et al[12] found that the fear of malpractice markedly decreased emergency medicine interns' enjoyment of their emergency room responsibilities. However, this fear decreased as they progressed through their residencies.

More worrisome are Helms and Helms'[13] findings from their review of 136 malpractice actions that involved residents and proceeded to litigation. Residents were on the side of the prevailing party in only 44% of cases, meaning that in 56% of the cases residents bore some responsibility in the judicial result. Residents need to understand that one's status as a trainee does not confer immunity from being named as a malpractice defendant.

Patterns of Malpractice at a Large Academic Medical Center

As we began to develop our malpractice professionalism seminar in the summer of 2008, we decided that it would be important to share concrete examples drawn from actual malpractice claims. Working with the NYU/Bellevue Risk Management Department, we collected data from the malpractice claims management database. We identified and reviewed all claims involving the Department of Surgery (including ambulatory, cardiothoracic, general, pediatric, transplant, vascular, and trauma surgeries) from July 2001 through May 2008.

During the seven-year study period, 18,753 surgical procedures were performed and 101 malpractice actions (formally known as "notices of claims") were brought against the Department of Surgery, representing 0.5% of all operations performed. At the time of data collection, 60 of the cases had been resolved (closed cases) and 41 were still in litigation.

Of the 60 closed claims, 33 (55%) progressed to a formal lawsuit. Thus, 27 (45%) of the notices of claims did not result in a filed lawsuit. Of the 33 cases in which a lawsuit was filed, 23 (70%) were settled for a monetary amount and 10 (30%) were closed without a financial settlement. Only 1 (3%) of the 33 resolved cases progressed to trial, and it was settled prior to verdict. Consequently, there were 23 malpractice monetary settlements resulting from the 18,753 surgical procedures performed. This yields a risk of 0.12%—in other words, roughly 1 of 1,200 surgical procedures at NYU/Bellevue results in an adverse legal action. This is an extremely low incidence of malpractice settlements and verdicts—a much lower rate than, in

our experience, practicing academic physicians generally believe to exist.

Among the 23 settled malpractice cases, 10 (43%) involved improper documentation, 7 (30%) cited inadequate informed consent, 8 (35%) involved a technical error, 6 (26%) were related to a system failure, and only 1 (4%) cited inadequate resident supervision. (Some of the 23 cases were associated with deviations in more than one of these areas.) Specific issues leading to a malpractice action included bowel perforation during laparoscopy, retained foreign bodies, arterial injury during resection of a neck mass, improper positioning during surgery, failure to follow up on a lung nodule revealed on a routine X-ray, and malfunction of a heart–lung machine.

One Model for Resident Professionalism Education in Malpractice

On the basis of our review of both national trends in malpractice claims and malpractice claims against NYU/Bellevue from 2001 to 2008, we prepared an evidence-driven, interactive professionalism seminar on malpractice. The target learners were 16 NYU surgical residents (spanning postgraduate years 1–5). Immediately before the seminar (which we delivered in October 2008), we asked them to complete a 13-question, written multiple-choice survey to determine their baseline level of malpractice understanding (Table 1). This study of deidentified surgical residents was approved by the New York University School of Medicine institutional review board.

Our resident learners' baseline knowledge was quite poor. Analysis of the pretest data revealed that the surgical residents correctly answered an average of 52% (SD 15%) of the 13 questions.

Immediately after the pretest, we delivered an interactive, hourlong seminar in which the surgical education team discussed the events that prompt patients to file malpractice claims and applicable malpractice law. The PowerPoint-based seminar included the definition of malpractice, statistics on the financial and emotional tolls of medical malpractice on physicians, examples of commonly cited forms of

Table 1

Comparison of 16 Surgical Residents' Understanding of the Causes, Process, and Resolution of Medical Malpractice Claims Before and After a Malpractice Seminar[*]

Question	Correct answer	No. (%) of residents giving correct answer	
		Pretest	**Posttest**
In order to establish medical malpractice has been committed, an attorney must prove:	A physician breached the local community standard of care	5 (31)	14 (88)
A formal lawsuit begins with:	Filing of a complaint	5 (31)	2 (13)
In the eyes of the law, resident physicians of all levels are expected to conform to the standard of care expected of attending physicians in their specialty field.	True	12 (75)	16 (100)
A physician is only subject to civil penalties for alterations made to a patient's chart after the fact.	False	14 (88)	13 (81)
What are the chances that you will be sued for malpractice in your career?	100%	7 (44)	16 (100)
Disclosure of information about a medical error increases the risk of a lawsuit being filed and of a larger settlement.	False	16 (100)	16 (100)
What is the percentage of surgical procedures that result in a malpractice action at your home institution?	0.3%	8 (50)	14 (88)
Most malpractice lawsuits proceed to trial and are decided by a jury verdict.	False	14 (88)	16 (100)
The most common root cause of surgical malpractice actions at your home institution is:	Improper documentation	11 (69)	16 (100)
What percent of a settlement typically goes to the malpractice attorney?	33%	5 (31)	12 (75)
What is the average time to resolution of a malpractice claim at your home institution?	3 years	3 (19)	7 (44)
What is the percentage of surgical cases at your home institution that result in a malpractice monetary settlement?	0.1%	8 (50)	15 (94)
The single most important aspect of informed consent to protect the surgeon is:	A doctor note in chart	2 (13)	14 (88)
Average		52.2% (SD 15.2)	80.8% (SD 10.0)
			$P < .001$, paired t test = 6.46

[*] Sixteen surgical residents across all levels of training at New York University Langone Medical Center/Bellevue Hospital responded to a 13-question multiple-choice test before and immediately after a one-hour interactive seminar on malpractice led by surgical education faculty in October 2008.

medical malpractice, the legal steps of a malpractice suit, discussion of how malpractice law affects residents, and the characteristics of surgical malpractice claims at this academic medical center. The seminar also included in-depth case reviews of seven specific claims, which were analyzed as examples of issues that can lead to a patient's filing a lawsuit. We concluded the seminar with recommendations and instruction on proper documentation (with examples of appropriate ways to correct errors when writing in a patient's chart), key aspects of informed consent and the language that should be used in obtaining it, and what residents should do (and not do) if they are sued.

At the conclusion of the seminar we asked the 16 residents to complete the questionnaire again. Analysis of residents'

posttest responses showed improvement to 81% (SD 10%) correct answers ($P < .001$, paired t test = 6.46). Before the seminar, the topics about which residents were least informed (≤50% answered correctly) were the basic tenets of malpractice law, the frequency of malpractice actions and settlements, plaintiff legal fees, the time until resolution of a malpractice claim, and important aspects of informed consent. Residents showed improvement in all these areas except one (initial step in a lawsuit) on the posttest. Additionally, on posttesting, the residents continued to struggle (≤75% answered correctly) with questions related to legal fees generated by malpractice actions, the time frame from the filing to resolution of a malpractice lawsuit, and the legal steps in the initiation of a lawsuit.

Recommendations

Residents' poor understanding of medical malpractice may be due to its omission from professionalism curricula. We believe the time has come to add an understanding of the causes and resolution of malpractice to the core resident curriculum. The increasing costs of medical malpractice litigation, the emotional toll of the malpractice process, the ordering of excessive tests for "defensive" medical purposes, and, most important, malpractice's impact on patient safety warrant improved residency education in malpractice law and issues. On the basis of our findings, we have added our malpractice seminar to the required professionalism curriculum for NYU/Bellevue surgical residents. It is important to prepare residents for this challenge which they

will surely encounter during their careers. Both residents and patients will be the beneficiaries.

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Which Experiences in the Hidden Curriculum Teach Students About Professionalism?

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Abstract

Purpose
To examine the relationship between learner experience in the "hidden curriculum" and student attribution of such experiences to professionalism categories.

Method
Using the output of a thematic analysis of 272 consecutive narratives recorded by 135 students on a medical clerkship from June through November 2007, the authors describe the frequency of these experiences within and across student-designated Association of American Medical Colleges–National Board of Medical Examiners professionalism categories and employ logistic regression to link varieties of experience to specific professionalism categories.

Results
Thematic analysis uncovered two main domains of student experience: medical–clinical interaction and teaching-and-learning experiences. From a student perspective the critical incident stories evoked all professionalism categories. Most frequently checked off categories were *caring/compassion/communication* (77%) and *respect* (69%). Logistic regression suggested that student experiences within the teaching-and-learning environment were associated with professionalism categories of *excellence*, *leadership*, and *knowledge and skills*, whereas those involving medical–clinical interactions were associated with *respect, responsibility and accountability*, *altruism*, and *honor and integrity*. Experiences of *communicating and working within teams* had the broadest association with learning about professionalism.

Conclusions
Student narratives touched on all major professionalism categories as well as illuminating the contexts in which critical experiences emerged. Linked qualitative and quantitative analysis identified those experiences that were associated with learning about particular aspects of professionalism. Experiences of teamwork were especially relevant to student learning about professionalism in action.

Our team had a patient with terminal small-cell lung cancer for which no further treatment could be done. Instead of dealing with the topic of the patient's death with just our team, we consulted the palliative care team. We met together first, discussed the patient's options, the goals of the patient, the goals of his family members, and our recommendations as the medical team in charge of his care. We came up with several end-of-life scenarios from which the patient could actively choose how he would live out the rest of his days. We then met with the family, four physicians, a nurse and me, a medical student. There were three family members present and the patient. At first, I wondered if the presence of so many people in white coats would be intimidating or offensive to the family, and thus inappropriate, but I was encouraged to attend by my attending and resident physicians. During the meeting, the patient's situation was addressed honestly in a straightforward manner. However, there was an obvious compassionate atmosphere created by the family members as well as from the large group of medical professionals demonstrating to the family that they care about the future of this patient. We maintained that the patient's goals were our primary goals, and the family's concerns were addressed individually and extensively. There was no stone left unturned, and no questions left unanswered. This was a discussion about the patient's death that had no underlying context of fear, avoidance or denial about the reality the patient faced. I think that this was the most appropriate way to handle the impending death of a patient without behaving like death is the enemy, but rather preparing to make a patient's death as comfortable and easy as possible for all involved.

> —Third-year, male medical student's professionalism narrative; professionalism categories checked off: *altruism, respect, caring/compassion/communication*

In recent years, narrative writing and reflection in various forms have been widely used to enhance professional development and inculcate professional values.[1–4] The rationale for using student narratives is a belief that the lived experience of students and their day-to-day immersion in this informal or "hidden" curriculum are a powerful influence on their professional development.[5–7] These experiences influence students' socialization into the norms and rituals of the organization, teach the conventions of interpersonal processes between students and teachers and patients and physicians, and demonstrate the complexities of relationships with other professionals.[8] The breadth and diversity of these particular experiences may be vast and difficult to comprehend or synthesize because students are exposed to various positive and negative role models and to different experiences as observers and participants in processes of patient care, teamwork, and teaching and learning.[7,9] Exposure to these experiences, and specifically to negative role modeling, may increase the likelihood of becoming cynical and adopting negative professional attitudes and behaviors.[10] Reflective writing and feedback may mitigate this risk. Selecting one

experience from among many could be described as an act of discernment.[11] Organizing a coherent *description* of context and action organizes and frames the experience. This reflective process is further enhanced when there is an opportunity for *thoughtful reflection* on an incident and one's point of view is established. This last activity (personal reflection) may lead to a higher level of learning from experience,[12] one that has the potential to bridge theory and practice, moving learner knowledge in the direction of *phronesis* (practical knowledge or wisdom in action), in many ways a critical capacity for professionals in performing fields such as medicine.[13,14] Writing about one's own experiences and observations in reflective essays and *telling them* through writing expands the ability to recognize the layered consequences of the phenomena, focuses one's attention on what is happening to the other, and represents what has been witnessed.[2] Recent publications have indicated that the level of reflection and learning from these essays may be further enhanced by specific faculty and peer feedback.[15]

The present study focuses on examining the relationship between medical students' learning experiences in the hidden curriculum and how they attribute these experiences to the categories associated with professionalism. Though narrative and reflection are in frequent use, we have not been able to find empirical research in the medical literature that would suggest which specific experiences in our working environments teach students about particular elements of professionalism. Instead, we uncovered only general statements about narrative reflection leading to better understanding of the professionalism categories discussed in the professionalism competency curriculum[16,17] and specific examples of deeper exploration of a particular category or term, such as *respect*.[16] Additionally, we have found no empirical studies examining whether all widely accepted domains of medical professionalism are discernable in students' critical incident narratives and whether these narratives might serve as a suitable resource for professional development seminars or small-group dialogues intended to serve as safe environments needed for reflection.[17,18]

At the Indiana University School of Medicine (IUSM), student narratives are used in all years as a pedagogic strategy to promote student maturation in the professionalism domain of the competency-focused curriculum. Among other uses, the third-year medicine clerkship requires students to record two Health Insurance Portability and Accountability Act–compliant critical incident narratives in a secure personal "professionalism journal."[19] The thematic analysis of the journal entries has been described elsewhere.[9] The present study focuses on the relationship between the domains and themes in the student journal entries and the Association of American Medical Colleges–National Board of Medical Examiners (AAMC–NBME)[20] categories of professionalism checked off by the students in completing the assignment. Our specific aims were to

- assess the extent to which student experiences covered widely accepted categories of medical professionalism,

- ascertain which kinds of experiences were most strongly associated with student learning about categories of medical professionalism, and

- assess the extent to which reflective dialogue focused on a limited number of student-selected narratives might also cover the major categories of medical professionalism.

Method

Many terms, definitions, and taxonomies of professionalism are available in the broad-ranging literature that describe the attributes of the "good" physician, professional values, professional ethics, and commitments of medicine.[5,21–23] One taxonomy that might be considered a reasonable gold standard emerged from a working conference cosponsored by the AAMC and NBME.[20] The qualities of the good physician in this formulation were captured in eight categories: (1) *altruism*, (2) *responsibility and accountability*, (3) *excellence and scholarship*, (4) *respect*, (5) *honor and integrity*, (6) *caring/compassion/communication*, (7) *leadership*, and (8) *knowledge and skills*.

The student narratives

Since February 2004, third-year IUSM medical students on their two-month internal medicine clerkship have been required to keep a professionalism

journal. Accessing a password-protected Web site, they are asked to record narratives of two rotation experiences, in which they were present as participants or observers, that manifested professionalism (or lack thereof).[9,19] After writing the narrative in a free-text area, they also check off any of the eight professionalism categories that they consider relevant to their experience. At the end of the clerkship, the clerkship director—the only person who has access to these narratives— collates and duplicates them for use in a small-group discussion. Group members first read through all of the narratives and then are asked to identify and read aloud one or more that caught their attention. A faculty-facilitated discussion of professionalism issues embedded in the selected narratives then ensues. Once the discussion is completed, the narratives are warehoused until the students graduate (to assure students that they are protected from any risk of reprisal). The IUSM institutional review board has approved the use of graduates' narratives for feedback, research, and publishing (approval # 0303-73),[9,16] as other ethics committees have done.[12]

We examined the entire group of narratives written during a six-month period and the subset of student-selected narratives discussed in the small groups. The primary data for this study were 272 written narratives entered into the professionalism journal by 135 third-year medical students during a six-month period from June through November 2007. During this period, 137 students rotated through their medicine clerkship. Of those, 113 (82.5%) students recorded two narratives, 12 (8.8%) recorded three, 10 (7.3%) recorded one, and 2 (1.4%) recorded none.

Analysis

We used several statistical analyses to explore the relationships between the students' experiences (domains and themes) that emerged in our earlier thematic analysis[9] and the professionalism categories checked off by the student–authors. First, we tabulated students' experiences within and across each professionalism category and then tested the significance of the association between each type of experience with each professionalism category using chi-square (or Fisher exact) tests for two-by-two tables. Second, we used logistic

regression models to predict students' preferential choice of specific professionalism categories (dependent variable) from varieties of experience in the narratives (independent variables). Candidate predictors for these final regressions included all experiences that had been associated with a professionalism category at $P < .2$ in chi-square tests, and additional covariates indicating the gender of the student and the presence or absence of a positive experience in the narrative. Third, to examine whether the faculty-facilitated small-group discussion covered all professionalism categories (at least over time), we examined the frequency and distribution of the critical incident experience types and professionalism categories in the 27 narratives selected by students for discussion in their professionalism seminars during the study period.

Results

Brief overview of student experiences

The analysis of students' experiences was rooted in the free-text narratives and the natural language of student "lived" experience, not in any predefined categorical language drawn from specific literature about professionalism. Some of the themes describing student experiences, nevertheless, used well-known values and behavioral terminology related to professionalism, such as *respect*, *caring*, and *responsibility*, whereas other student narratives included behaviors not specifically cited elsewhere in the professionalism literature, such as *capitalizing on teaching opportunities*, *creating an (un)welcoming environment*, and *spending time taking care of patients, patients' education and understanding*. Our analysis of student experience uncovered two large domains: descriptions of medical–clinical interactions (81.8% of narratives) and description of interactions in the teaching and learning environment (18.2% of the narratives). Medical–clinical interactions included observations of various role models interacting with patients, families, coworkers, and colleagues. Teaching and learning environment interaction narratives were accounts of students' experiences as learners in the clinical setting. A more detailed description of these narrative themes and exemplar narratives can be found in Karnieli-Miller et al[9] (2010). During the analysis process

of this study, a few small changes were made in the original classification for greater clarity. One subcategory in the initial analysis that focused on *taking full responsibility for patient care* was moved to the theme of *demonstrating responsibility*; another theme, *going above and beyond and caring and altruism*, was split into two separate themes (each accounting for 11 narratives). These changes were made a priori rather than a posteriori (after regression analyses).

Distribution of students' experiences within and across professionalism categories

Table 1 shows the associations students made between their experiences and the categories of professionalism. More than three-fourths (77%) indicated that more than one category was relevant to their narrative. Students checked off a mean of 2.9 categories for each narrative (SD = 1.8, range 0−8), suggesting that the narratives are rich with heuristic value.

Table 1 also illustrates that the distribution of identified experience varieties spanned all eight professionalism categories. The most frequently selected categories were *caring, compassion, and communication* (checked off in 77% of the narratives) and *respect* (checked off in 69%). These categories were seen as relevant to many varieties of medical–clinical interactions, most frequently *manifesting respect*, followed by *managing communication challenges* and *spending time on patient education*. The third most frequently selected professionalism category was *responsibility and accountability*. All other professionalism categories were checked in at least 20% of the narratives, except for *excellence and scholarship* (16%), which was most often seen as relevant to *capitalizing on teaching opportunities* in the domain of the teaching and learning environment.

The most frequent student experience, classified as *manifesting respect*, accounted for 26.8% of all narratives and the plurality of experience varieties within five of the eight professionalism categories (>20% each), especially in the categories of *respect* (accounting for 33.2% of student experiences producing check offs in this category) and *honor and integrity* (31.3%). The next-most-frequent kinds of student experience were those classified as *managing*

communication challenges, *spending time on patient education*, and *demonstrating responsibility*. All three were associated with relatively high-frequency selections of professionalism categories (accounting for 8.4%–23.6% of all checked off items). *Capitalizing on teaching opportunities*, within the *teaching and learning* domain, was most often associated with check offs in two professionalism categories: *excellence and scholarship* (accounting for 27.3% check offs) and *knowledge and skills* (accounting for 20.9% of check offs).

Prediction of professionalism categories from students' experiences

Table 2 displays associations between varieties of students' experiences and professionalism categories that are specific to the pair, as demonstrated by logistic regression models. For example, *altruism* was checked significantly more often when students described experiences that involved *communicating and working in teams* and experiences with role models demonstrating *caring and altruism*. Even though *manifesting respect* was the most frequently identified experience among all narratives when students checked off *altruism* (Table 1), the percentage of this experience was not significantly higher than in other kinds of narratives that did not check *altruism* as the professionalism category. As a consequence, when using logistic regression, there was no significant relationship between this kind of experience (*manifesting respect*) and *altruism*. A student experience with people *demonstrating responsibility* significantly predicted selection of *responsibility* as the professionalism category.

The overall pattern in Table 2 shows that check-offs of the professionalism categories *excellence and scholarship*, *leadership*, and *knowledge and skills* were strongly associated with student experiences in the *teaching and learning environment* domain such as *capitalizing on teaching opportunities* (OR > 10), with or without experiences of *creating an (un)welcoming environment* (OR = 8.9). They were also associated with *communicating and working in teams* (OR ≥ 4.3) and positive narratives (OR ≥ 2.2). Because the professionalism category of *caring, compassion, and communication* was frequently checked off for narratives involving the majority

Table 1

Frequency (Percentages) of Student Experiences Associated With Each AAMC–NBME Professionalism Check off Category, Internal Medicine Clerkship, Indiana University School of Medicine, 2007*

Student experience domain; varieties of experience within the domain described in 272 narratives	% of 272 narratives	AAMC–NBME professionalism categories checked off by students							
		Altruism No. (%)	Responsibility and accountability No. (%)	Excellence and scholarship No. (%)	Respect No. (%)	Honor and integrity No. (%)	Caring, compassion, and communication No. (%)	Leadership No. (%)	Knowledge and skills No. (%)
Experience with medical–clinical interactions									
Manifesting respect	26.8	12 (21.8)†	25 (20.3)	7 (15.9)†	62 (33.2)†‡	25 (31.3)†	54 (25.8)†	19 (22.9)†	9 (13.4)
Managing communication	18.4	8 (14.5)	18 (14.6)	4 (9.1)	34 (18.2)	14 (17.5)	43 (20.6)‡	10 (12.0)	11 (16.4)
Spending time on patient education	16.2	8 (14.5)	20 (16.3)	7 (15.9)	25 (13.4)	11 (13.8)	37 (17.7)‡	7 (8.4)	8 (11.9)
Demonstrating responsibility	15.1	6 (10.9)	29 (23.6)†‡	4 (9.1)	21 (11.2)	9 (11.3)	25 (12.0)	8 (9.6)	10 (14.9)
Communicating and working in teams	4.8	6 (10.9)	8 (6.5)	3 (6.8)	8 (4.3)	8 (10.0)	9 (4.3)‡	6 (7.2)	4 (6.0)
Caring and altruism	4.0	5 (9.1)	2 (1.6)	1 (2.3)	6 (3.2)	4 (5.0)	10 (4.8)‡	2 (2.4)	2 (3.0)
Going above and beyond	4.0	3 (5.5)	3 (2.4)	1 (2.3)	4 (2.1)	1 (1.3)	8 (3.8)‡	0 (0)	2 (3.0)
Experience within the teaching and learning environment									
Creating an (un)welcoming environment	6.6	1 (1.8)	3 (2.4)	2 (4.5)	13 (7.0)‡	1 (1.3)	5 (2.4)	12 (14.5)	2 (3.0)
Capitalizing on teaching opportunities	6.6	3 (5.5)	9 (7.3)	12 (27.3)†	8 (4.3)	3 (3.8)	6 (2.9)	14 (16.9)†	14 (20.9)†‡
Learning from peers	3.7	3 (5.5)	4 (3.3)	2 (4.5)	4 (2.1)	3 (3.8)	8 (3.8)‡	4 (4.8)	5 (7.5)
Dealing with attending	1.5	0 (0)	1 (0.8)	1 (2.3)	1 (0.5)	0 (0)	0 (0)	1 (1.2)	0 (0)
Paying attention	0.7	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	2 (1.0)‡	0 (0)	0 (0)
Having space	0.7	0 (0)	0 (0)	0 (0)	1 (0.5)	0 (0)	2 (1.0)‡	0 (0)	0 (0)
Demonstrating honesty	0.4	0 (0)	1 (0.8)	0 (0)	0 (0)	1 (1.3)	0 (0)	0 (0)	0 (0)
Total: No. (% of 272)	299 (109.5)§	55 (20)	123 (45)	44 (16)	187 (69)	80 (29)	209 (77)	83 (31)	67 (25)

* This table's information is based on the frequencies of a thematic analysis of 272 professionalism journal entries written by 135 students in 2007 describing experiences in their internal medicine clerkship that "taught you something about professionalism and professional values" and the AAMC–NBME (Association of American Medical Colleges–National Board of Medical Examiners) professionalism categories students checked off for these narratives.

† Most frequent variety of student experience among narratives that checked a specific professionalism category.

‡ Most frequently checked professionalism category among narratives about a given variety of student experience.

§ The number (and percent) of narratives summed over the varieties of student experiences exceeds 272 (and 100%) because sometimes a single narrative was classified into more than one variety of experience. Similarly, multiple professionalism categories may be checked off in each narrative, so sums over the categories exceed the actual numbers of narratives.

Table 2

Summary of Logistic Regression Modeling: Student Experiences as Predictors of AAMC–NBME Professionalism Category Check offs: Significance of Adjusted Odds Ratios (and 95% Confidence Intervals) and P Value, Internal Medicine Clerkship, Indiana University School of Medicine, 2007*

Student experience (independent variable): within each experience, the varieties of experience described in narratives	AAMC–NBME categories checked off by students (dependent variables); within each category, the adjusted odds ratios (95% CI) P values							
	Altruism	Responsibility and accountability	Excellence and scholarship	Respect	Honor and integrity	Caring, compassion, and communication	Leadership	Knowledge and skills
Experience with medical–clinical interactions								
Manifesting respect	†	‡	‡	4.4 (2.2, 8.9) P < .001	2.2 (1.2, 4.2) P < .05	‡	†	‡
Managing communication	†	†	‡	†	†	‡	‡	†
Spending time on patient education	†	‡	†	‡	†	‡	‡	†
Demonstrating responsibility	†	4.2 (2.1, 8.8) P < .001	†	‡	†	‡	‡	†
Communicating and working in teams	7.5 (2.1, 26.8) P < .01	‡	4.8 (1.0, 22.9) P < .05	†	7.5 (2.2, 25.6) P < .01	†	4.3 (1.3, 14.0) P < .05	4.5 (1.0, 19.6) P < .05
Caring and altruism	3.7 (1.1, 13.1) P < .05	‡	†	†	†	†	†	†
Going above and beyond	†	†	†	‡	‡	†	†	†
Experience within the teaching and learning environment§								
Creating an (un)welcoming environment	‡	‡	†	†	‡	0.2 (0.06, 0.5) P < .01	8.9 (2.9, 27.1) P < .001	‡
Capitalizing on teaching opportunities	†	†	12.0 (4.1, 35.0) P < .001	‡	‡	0.1 (0.05, 0.4) P < .001	10.1 (3.1, 32.8) P < .001	12.1 (3.8, 38.9) P < .001
Learning from peers	†	†	†	‡	†	‡	‡	‡
Other								
Positive narratives	4.4 (1.6, 11.7) P < .01	‡	17.0 (2.2, 133.1) P < .01	‡	2.3 (1.1, 4.6) P < .05	2.8 (1.5, 5.0) P < .001	2.2 (1.0, 4.6) P < .05	14.1 (3.2, 63.2) P < .001

* This table's information is based on logistic regression analysis of the relationship between a thematic analysis of 272 professionalism journal entries written by 135 students in 2007 describing experiences in their internal medicine clerkship that "taught you something about professionalism and professional values" and the AAMC–NBME professionalism categories students checked off for these narratives.

† No association by chi-square analyses: P > .20.

‡ P ≥ .05.

§ The varieties of experiences of dealing with attending, paying attention, having space, and demonstrating honesty had frequencies too low to be modeled in conjunction with other themes.

of student experiences within the medical–clinical interactions domain, but not in experiences in the teaching and learning environment domain (Table 1), there are significant negative associations between the latter two varieties of experience (*creating an [un]welcoming environment* [OR = 0.2] and *capitalizing on teaching opportunities* [OR = 0.1]) and the professionalism category of *caring, compassion, and communication*. All other professionalism categories (i.e., *altruism, responsibility and accountability, respect,* and *honor and integrity*) are positively and significantly associated with selected experiences in the medical–clinical interaction domain, as shown in Table 2. The student experience that has a significant relationship with more professionalism categories[5] than any other (including *altruism, honor and integrity, excellence and scholarship, knowledge and skills,* and *leadership*) is *communicating and working in teams* (for illustrative quotes, see Table 3).

Among all the narratives, positive narratives were significantly predictive of checking off all professionalism categories, except for the categories of *responsibility and accountability* and *respect*. The gender of the student narrative author had no significant relationship with check offs in any of the professionalism categories.

Experiences and professionalism categories present in narratives students selected for discussion

During the six-month study period, 12 small-group discussions were facilitated by two of the authors (T.S.I. and R.M.F.). During that period, 27 out of the 272 narratives were selected by the students for discussion in these groups. Table 4 displays the distribution of student experience and professionalism categories checked off within this subset of narratives.

As shown in Table 4, all professionalism categories were checked off for the narratives selected for discussion. Most of these narratives (85.2%) were about *caring, compassion, and communication,* and more than half were about *responsibility and accountability* (55.6%) and *respect* (55.6%). Except for *respect,* these numbers were higher than the frequency in the entire group of narratives (85.2% versus 77%, 55.6% versus 45%, and 55.6% versus 69%,

respectively). Less frequently chosen for discussion were narratives focusing on *excellence and scholarship* (11.1%) and on *leadership* (22.2%), which are related to the *teaching and learning environment* domain (e.g., *capitalizing on teaching opportunities*). The frequency of positive (55.6%), negative (37.0%), and hybrid (7.4%) narratives in the subset selected for discussion was similar to their distribution within the general data set.

Discussion

We hope the findings of this study will be encouraging to faculty in medical schools who have chosen to use reflective narratives as a tool to teach professionalism. The experiences described in the student narratives are diverse and touch on all of the conventional categories of professionalism. This is certainly the case for the overall sample of narratives, and even for the limited number of narratives students chose to discuss in the small-group discussions. Although in other circumstances students do not specifically cite a positive effect of written reflections on their learning of professionalism,[24] our data suggest that students do connect their experiences in the hidden and informal curriculum directly and immediately to various dimensions of professionalism.

In comparing the frequency of student check offs of AAMC–NBME[20] professionalism categories and our previous analysis of narrative content,[9] some differences were apparent. From the students' perspective, for example, most of the narratives were about *caring, compassion, and communication, respect,* and *responsibility and accountability*. From the researchers' perspective, the relative prevalence order of these narratives was different: *respect, communication,* and *responsibility*. This difference may prevail because the research team made a distinction between caring and communication, and even specifically between the different types of communication (e.g., focused on managing communication challenges, such as breaking bad news, or on educating), as well as between narratives that differed by the type of communication partner (communicating with patients and family members versus communication with teams or students). Our findings support the importance of

effective communication to professionalism as emphasized in a recent paper focused on patients', nurses', and physicians' perspectives on professionalism.[25] Students expect professionals to communicate clearly, compassionately, and patiently with patients, family members, colleagues, and themselves.

The findings in this study also deepened our understanding of the specific behaviors that may embody professionalism from a student perspective[25,26] and of the circumstances in which students are actively learning about professionalism. The behaviors included medical–clinical interactions and the experiences in the teaching and learning environment. The logistic regression analysis results suggest that students differentiate between behaviors that are supposed to be enacted in the clinical setting (i.e., with patients, family members, and colleagues) and those that are seen as important in relationships between themselves and faculty. Behaviors manifesting *altruism, responsibility, honor and integrity,* and *respect* are situated in the medical–clinical interaction domain, whereas *excellence, leadership,* and *knowledge and skills* are observable in the teaching and learning environment. The findings show that *caring, compassion, and communication* specifically was negatively (less frequently) associated with checked items in the teaching and learning domain, suggesting that students are not expecting their teachers to be compassionate toward them as students. This is an interesting discrimination among behaviors and expectations, perhaps especially because students themselves are a "vulnerable population" in some learning environments and might even benefit from being treated themselves with compassion and caring. They might then learn how to employ these behaviors in interactions with patients if they experienced it themselves in teaching and learning interactions. In the narratives, they express these thoughts and experiences but connect them as to lack of excellence and/or knowledge and skills, not to caring and compassion. This also underscores the value conflicts[27] inherent in the various role expectations that learners have to meet. Ginsburg and colleagues[28] argue that learners facing a conflict of professional values often use

Table 3
Illustrative Quotes From Experiences of "Communicating and Working Within Teams," the AAMC–NBME Categories Checked off, and Brief Commentaries and Interpretations, Internal Medicine Clerkship, Indiana University School of Medicine, 2007*

AAMC–NBME categories checked off[†]	Illustrative narrative from student professionalism journal entries	Brief commentary and interpretation
Altruism, Caring, compassion, and communication, Leadership, Knowledge and skills	The best example I've seen of professionalism at Wishard (public hospital) are the members of the ACE team…. I was really impressed by how all of the different members of the team—an attending, residents, nurses, PT, and a pharmacist—worked together. For example, one of my patients, an elderly female whom we already knew had many medical and social problems, was suffering from cataracts in both eyes. We knew this and made a note of it, but the ACE team resident and attending went out of their way to set up an ophthalmology consult to evaluate the patient for surgery, and then make sure that they could get it paid for. In the meantime, the nurse set up a home visit for services for the blind so she could get along better at home while she was waiting for surgery, or if she couldn't get it. I was so pleased my patient could get that kind of care.	The student notices that all team members went "out of their way" in an effort to help the patient. Taking care of all the details and possible obstacles when caring for her. This is marked as altruism, because it is doing more than is expected of you.
Altruism, Responsibility and accountability, Excellence and scholarship, Respect, Honor and integrity, Leadership, Knowledge and skills	The night my resident was supposed to be on call, I witnessed how the team concept of medicine functions and how residents/interns/attendings work together to help each other out. As the "bell was about to ring" for no new admissions, our team suddenly got three new admissions. The intern that was scheduled to leave was suddenly devastated as it was his first anniversary and he had been looking forward to getting home and spending it with his wife, but with three new admissions that would be very difficult. Though my resident was on call and had a very long night in front of him, he told the intern to go home and that he would handle the new admissions. With a full load of patients that were his and some not, I saw my resident absolutely shine as he juggled his patients, other doctors' pts, and new pts in stride without wasting a moment. Though he was exhausted, by 4 AM, the night had finally slowed to the point where he could get some sleep…. 15 minutes later a page with a new admission. As the next morning finally rolled around, the attending told the resident to go ahead and get home if there were no major changes in our pts status and to not wait to round. In the end, the intern got home to his wife for his first anniversary, the resident worked his butt off but got home a little bit earlier than expected for his hard work because the attending understood the day he had just had.	This is a narrative focused on caring for your team members; giving of yourself to help others; and being responsible for other members of your team, as well as for the patients.
Responsibility and accountability, Respect, Honor and integrity, Caring, compassion, and communication, Leadership, Knowledge and skills	One thing I have learned this month is the value of communication. Internal medicine is an incredibly complex field, and a team involving the physicians, residents, medical students, nurses, patients, and patient families is infinitely more successful than when these groups work and make decisions independently of each other. Of course, proper communication takes significant effort on the part of all parties involved. One of my patients experienced an adverse outcome this week, which I feel could have been avoided. Breakdowns in communication between different groups of caregivers delayed scheduled treatment for the patient. He was passed between teams and moved around the hospital. In the end, I do not believe that the person making the final decisions for the patient's care completely understood the patient's condition. There was certainly nobody at fault for this patient's outcome, as I believe everybody involved made an effort in good faith to provide him with optimal care, and his result may have been the same, no matter how perfectly his therapeutic plan was crafted and executed. However, this experience highlights for me the importance of making sure that decisions are made as a team and that everybody on the whole team caring for a patient understands what needs to be done.	The student addresses the complexity of medicine, and working within teams, to allow responsible care for patients. The focus is on the important role of communication.

* This table presents illustrative quotes from the theme *communicating and working with teams* that emerged in a qualitative thematic analysis of 272 narratives written in an internal medicine clerkship, June to November 2007, at Indiana University School of Medicine. This theme included only 4.8% of the stories but had a significant relationship with five professionalism categories (*altruism*, *excellence and scholarship*, *honor and integrity*, *leadership*, and *knowledge and skills*).

† AAMC–NBME indicates Association of American Medical Colleges–National Board of Medical Examiners.

"dissociation" as a strategy to "step out of" the "double-bind" that such a conflict creates for them. The potential negative impact of dissociative coping strategies on professional identity formation deserves further attention.

One experience, *communicating and working within teams*, seems to be a key driver for five professionalism categories (in both the medical–clinical interactions and teaching and learning environment domains). Even though relatively few narratives were identified within this theme, these experiences were powerful ones that elicited thoughts of various professionalism categories, possibly indicating the special importance of teamwork for both patient care and student learning. Yet it is interesting that teamwork in itself is not explicitly considered an attribute of professionalism.[21] Student narratives, as well as a burgeoning literature in quality and patient safety, may give us pause to

Table 4

Frequency of Professionalism Categories Checked off by Students Within the 27 Professional Journal Entries Selected by Students for Facilitated Discussion, June to November 2007*

Categories, demographics, and domains	No. (%) of 27 narratives
Professionalism categories checked off[†]	
Caring, compassion, and communication	23 (85.2)
Responsibility and accountability	15 (55.6)
Respect	15 (55.6)
Honor and integrity	7 (25.9)
Leadership	6 (22.2)
Knowledge and skills	5 (18.5)
Altruism	3 (11.1)
Excellence and scholarship	3 (11.1)
Type of narrative	
Positive	15 (55.6)
Negative	10 (37.0)
Hybrid	2 (7.4)
Sex of student author	
Female	15 (55.6)
Male	12 (44.4)
Student experience domains	
Medical–clinical interactions domain	20 (74)
Teaching and learning environment domain	7 (26)

* This table includes the distribution of 27 out of the 272 narratives that were selected for discussion by third-year medical students in Indiana School of Medicine during 12 small-group discussions in a six-month study period, June to November 2007.
† The number (and percent) of narratives summed over the varieties of student experiences exceeds 27 (and 100%) because sometimes a single narrative was classified into more than one variety of experience.

reconsider the importance of teams and teamwork as an attribute of professionalism.

The significant relationship between various professionalism categories and positive narratives, and the fact that the positive narratives were in the majority, is reassuring and may alleviate general concerns about overweighting lapses of professionalism[27] in the use of narrative and reflection and in the hidden curriculum in general. It seems that students notice, appreciate, and learn about various forms of professionalism from positive (as well as negative) role models, and acknowledge and appreciate actions that reflect positively on us as professionals. In particular, positive narratives seem to be associated with learning about *excellence* and *knowledge and skills*.

Our findings come from what we acknowledge may be a unique setting. The study was conducted in one institutional setting and within a single clerkship. In addition, although 272

narratives may be a relatively large number for qualitative analysis, some of the themes had only a few narratives, and our sample size was too small for the logistic regression analyses to be feasible across all varieties of experience. Whatever the limitations of this study, we learned from our own findings and would encourage faculty using narrative and reflection as a pedagogic method for teaching and learning about professionalism in medicine elsewhere to continue in their efforts and to pursue similar research in order to discover the type of behaviors that relate to the theoretical concepts of professionalism in their own environments.

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Does One Size Fit All? Building a Framework for Medical Professionalism

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Abstract

Purpose
Medical professionalism has gained global attention over the past decade, but there is a paucity of literature on the universal applicability of the dominant professionalism framework developed in the West. This study proposes an institutional approach to build a framework for medical professionalism that incorporates historical and sociocultural contexts.

Method
From 2008 to 2009, the authors adopted nominal group technique (NGT) to determine professional competencies valued by 91 critical stakeholders of medical education (divided into 12 discipline-specific groups) at their institution and in their native society, Taiwan. An expert committee subsequently constructed a framework for professionalism which accounted for a literature review and their understanding of the institution's values and historical roots. To confirm that the framework encompassed the attributes nominated by NGT participants, the authors analyzed transcripts of NGT exercises to refine the final document.

Results
Each of 12 NGT groups raised 5 to 23 core competencies and determined the most important five competencies by summing participants' ratings of each item. The expert panel reached consensus on a framework that included eight competencies. The framework differs from the Western framework in the centrality of self-integrity, harmonizing personal and professional roles. Text analysis of the NGT transcripts demonstrated that the framework successfully incorporated top-ranked NGT results.

Conclusions
This study challenges the universal applicability of the Western framework of medical professionalism and proposes a process to build a professionalism framework that reflects the cultural heritage and the values of local stakeholders.

Medical professionalism has gained global attention over the past decade.[1–4] Ninety professional organizations worldwide have endorsed the Physician Charter,[5] which, while acknowledging the diversity of medical practices and traditions in its preamble, reaffirms "the

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fundamental and universal principles and values of medical professionalism" based on common themes identified by the representatives from the American Board of Internal Medicine, the American College of Physicians and American Society of Internal Medicine, and the European Federation of Internal Medicine.[6,7]

The editor of the Physician Charter[5] asks, "Does this document represent the traditions of medicine in cultures other than those in the West, where the authors of the charter have practiced medicine?" Before this issue was examined further, organizations adopted the charter quickly across specialties and countries internationally.[5] As a result, non-Western countries are adopting medical professionalism according to the North American forms of accreditation standards for both undergraduate and graduate medical education.[8,9] The Accreditation Council for Graduate Medical Education (ACGME) has set up an international division (ACGME-I) to answer requests from international residency programs to ensure that these programs meet ACGME-I standards, including guidelines for professionalism.[10]

In Taiwan, where our study takes place, the regulatory body for postgraduate training adopted the ACGME's six competencies, including professionalism.[11] The agency that accredits Taiwan's medical schools is also in the process of revising its standards according to the Liaison Committee on Medical Education standards, which includes a new standard on professionalism.[12]

Even as agencies and professional organizations adopt standardized guidelines for professionalism, scholars continue to emphasize that professionalism is context dependent[13] and is a social construct.[3] This social construct is defined within a sociocultural context at a particular time. Some sociologists raise the issue that, whereas influential scholars, groups, and organizations in North America and Europe dominate the discourse of medical professionalism,[14] there is a paucity of literature on the universal applicability of this framework.[15–17] This study addresses a gap in the literature by developing a non-Western framework and comparing it with known Western frameworks. We propose to adopt

sound methods to construct a professionalism framework that accounts for non-Western historical and sociocultural contexts. We illustrate this process with a case study in Taiwan.

Background

Medical professionals in Taiwan have enjoyed much respect and autonomy since the Japanese established the first medical school here during their 50 years of colonial rule between 1895 and 1945. In the decades that followed, medical professionals not only provided medical and public health services but also played active leadership roles in the modernization and democratization of the country. The establishment of the National Health Insurance in 1995 limited the total budget of medical institutions, which put financial pressures on physicians to control cost and to increase profit. As physicians became increasingly interested in services not covered by the National Health Insurance, such as cosmetic treatments, their professional image eroded.[18,19] In response to these public concerns, especially about doctors prioritizing self-interest over patient interest, medical educators in Taiwan are contemplating how to cultivate the qualities of a desirable physician.[20]

Our institution, National Taiwan University College of Medicine (NTUCM), serves as an example of a university seeking to address its nation's pursuit of medical professionalism. Historically, NTUCM was the first medical school established in Taiwan by the Japanese during their governance of Taiwan. Historic icons depict our institution's professionalism tradition. The NTUCM Medical Humanities Museum, for example, located in a Japanese-constructed building, is a symbol of medical professionalism education with Hippocratic-like oaths in Japanese on display and the World Medical Association's Declaration of Geneva[21] inscribed on the entrance wall. As we considered our institution's professionalism traditions, we also accounted for current influences; today, the majority of the current faculty received their advanced training and/or degrees from the United States.[22]

The process we describe in this report addresses these complex historical and modern perceptions and the lack of the concept of "medical professionalism" in traditional Taiwanese culture, where Hippocratic tradition is unfamiliar to nonmedical professionals, and Confucian doctrines are emphasized starting at the elementary education level. Instead of imposing foreign preexisting frameworks or nostalgic doctrines,[23] we developed a framework of professionalism for NTUCM de novo. We will discuss the advantages of adopting this framework over known Western frameworks in a Confucian cultural context.

Method

We employed three methods in this study: (1) nominal group technique (NGT), (2) expert committee, and (3) text analysis.

NGT

Through literature reviews and consultations of experts, we determined NGT to be an effective and efficient method to elicit group values and derive consensus.[24–27] NGT is a structured procedure for gathering insight from groups of people. In the NGT process, all group members have equal opportunity to present their views, all views have equal weight, and the process for everyone to list all their ideas for discussion avoids problems associated with traditional group meetings, such as dominating personalities or obedience to authority.[24–26] The method is used in management, clinical guidelines creation, and course evaluation in medical education.[27]

NGT participants. In our NGT process, we based the selection of participants on the purposive sampling[28] method. We asked the chairs of various departments (including internal medicine, surgery, obstetrics–gynecology, pediatrics, nursing, and social work) at the National Taiwan University Hospital to recommend those health care workers (including chief residents, attending physicians, intensive care unit nurses, operating room nurses, ward nurses, social workers, public health workers, and hospital volunteers) whom the chairmen believed possessed differing views within each department. We also asked the most active nongovernment patient support organization, the Taiwan Healthcare Reform Foundation, to suggest participants from a variety of patient support groups. Most of the potential participants joined the study or recommended other suitable participants.

Ninety-one people participated in the NGT meetings between 2008 and 2009. We organized these participants into 12 NGT groups according to their occupation: attending physicians, chief residents, medical humanities educators, intensive care unit nurses, operating room nurses, ward nurses, social workers, public health workers, standardized patients, hospital volunteers, medical students, and patient advocates. The demographic data of the participants are shown in Table 1. Our study protocol was reviewed and approved by the National Taiwan University research ethics committee.

NGT procedure. We oriented each group to the purpose of the meeting and the procedure that would be followed. The first step was for each participant to write down what he or she considered to be the essential abilities of a professional doctor. The purpose of this exercise was to capture participants' expectations regarding medical professionals. In the second step, participants took turns naming one item from their list at a time without further discussion. This process continued until all participants had expressed all of their ideas. In step three, the participants discussed all items and combined any closely related ideas into a single item. When determinations were not unanimous, the person who initially raised the item could decide whether or not to combine the idea or leave it as a separate item.

In the fourth step, each participant selected five items he or she regarded as most important and voted on these five items using a five-point Likert-type scale, where 5 = most important and 1 = least important. The fifth step was to sum the voting results and rank the items.

Expert committee

After the NGT meetings, the dean of our medical college convened an expert committee to discuss the results of all NGT meetings. The expert committee consisted of the dean, two associate deans, and three senior faculty members involved in curriculum planning. The

Table 1

Demographic Data of 91 Nominal Group Technique (NGT) Participants* by Professional Group in a Study to Identify Attributes of Professionalism, National Taiwan University College of Medicine, 2008–2009

Group	Number of participants	Average age (±SD)	Average years in position (±SD)
Attending physicians	6	43.0 (±4.8)	8.2 (±1.1)
Chief residents	8	31.5 (±3.5)	3.5 (±1.1)
Medical humanities educators	7	45.8 (±3.1)	12.2 (±6.5)
ICU nurses	7	31.9 (±3.9)	8.7 (±4.1)
Operating room nurses	7	39.1 (±6.1)	16.7 (±8.5)
Ward nurses	8	41.6 (±3.8)	18.3 (±3.0)
Social workers	9	34.7 (±7.4)	7.4 (±5.8)
Public health workers	4	43.8 (±10.1)	15.3 (±7.1)
Standardized patients	8	56.5 (±6.5)	14.9 (±13.8)
Hospital volunteers	8	50.6 (±7.5)	4.5 (±4.5)
Medical students	9	22.8 (±4.0)	3.4 (±1.2)
Patient advocates	10	40.3 (±15.2)	4.0 (±4.0)

* We adopted NGT to determine professional competencies valued by critical stakeholders of medical education at their institution and in society, and organized 91 participants into 12 groups according to their occupation.

committee also reviewed well-known published frameworks of medical professionalism, including the Association of American Medical Colleges' Medical School Objectives,[29] the ACGME Outcome Project,[9] the Physician Charter,[6,7] "The duties of a doctor" of the General Medical Council,[30] "The Scottish Doctor,"[31] CanMEDS,[32] and Stern's[33] treatise on medical professionalism. The committee constructed a professionalism framework to guide our professionalism curriculum development through consensus meetings. In the meetings, the committees considered the historical and cultural backgrounds of our institution and the core competencies of medical professionalism informed by our NGT process and the literature.

Text analysis of NGT transcript

We recorded and transcribed NGT meetings verbatim. The transcript was 123 pages, containing 113,547 Chinese characters. After the expert committee constructed the framework, we used NVivo 8.0 software (QSR International Pty Ltd.; Doncaster, Victoria, Australia) to conduct a text analysis of the transcripts of the 12 NGT sessions. The purpose of this analysis was to ensure that the expert committee represented the opinions about professionalism attributes nominated by the participants in the consensus framework.

Results

Our process yielded three forms of results: (1) the NGT process rating results, (2) the framework constructed by the expert committee, and (3) the review of the transcript to confirm the consensus framework.

The NGT process voting results

The number of core competencies of medical professionalism agreed on by NGT groups (Table 1) ranged from 5 to 23. Voting results of the top five items of each group are shown in Supplemental Digital Table 1, http://links.lww.com/ACADMED/A57.

The framework constructed by the expert committee

Among the published frameworks of professionalism, the framework proposed by Stern[33] influenced our committee most. Serendipitously, Stern's pictorial framework also closely resembles the façade of the NTUCM Medical Humanities Museum—a historical symbol of medical professionalism at our institution. Stern depicts medical professionalism in the shape of a Greek temple, with three foundational steps (clinical competence, communication, and ethics) and four columns (humanism, excellence, accountability, and altruism). After iterative deliberation, the expert committee reached consensus that our visual

framework should include "integrity" across the tops of the columns that make up Stern's framework because integrity is the key for integrating the different principles of medical professionalism. Furthermore, the committee added blank columns on the second level of our framework to leave space for medical professionals to fill in their additional personal professional values. Our institutional framework for medical professionalism is shown in Figure 1.

The review of the transcript to confirm the consensus framework

After the expert committee constructed the NTUCM framework for medical professionalism, we reexamined the transcripts of the NGT meetings. We reviewed the top-ranked items to see whether the items nominated by each group (Supplemental Digital Table 1, http://links.lww.com/ACADMED/A57) could be categorized into the eight competencies highlighted in the newly constructed framework (Figure 1). For instance, the visual framework "Ethics" includes confidentiality, medical ethics, and high moral standards. "Humanism" encompasses empathy, respecting lives, and respecting other individuals. "Accountability" includes responsibility, accountability to team members, and responding to societal needs. "Altruism" includes serving others and primacy of patients. "Integrity" includes honesty, frankness, adhering to one's principles, and admitting one's failures.

By analyzing the transcripts of the meetings according to the original wording of the participants, we were able to place most items identified by NGT participants within the NTUCM framework developed by the expert committee. Figure 2 shows the mapping of the NGT results on the NTUCM's framework for professionalism. Four related items identified by NGT participants did not fit neatly into the named steps or pillars: "management of personal time and lifestyle," raised by teaching chief residents; "self-care," raised by social workers; "time management" (time for family and recreations), listed by students; and "healthy lifestyle," raised by patient advocates. Although the relative importance of the eight professional values differed from one group to another, each value was addressed by all groups.
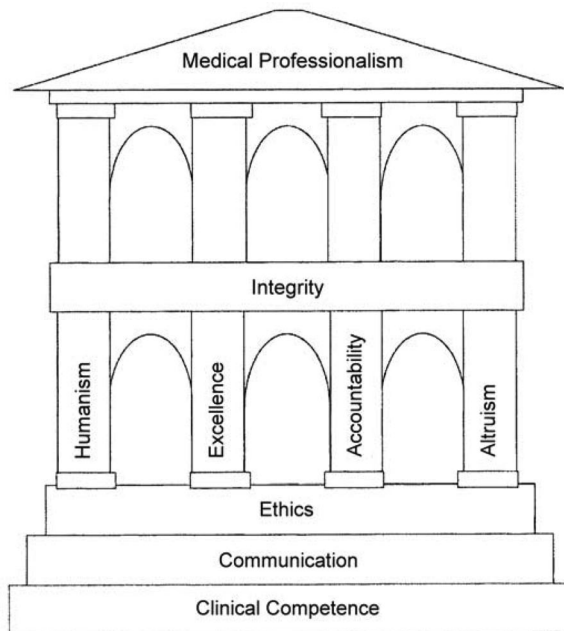
Figure 1 National Taiwan University College of Medicine's framework for medical professionalism. Adapted from Stern DT. Measuring Medical Professionalism. New York, NY: Oxford University Press; 2005. By permission of Oxford University Press, Inc. (www.oup.com).

By pooling all the votes and calculating the overall ratings of each professional value, we elucidated the values most emphasized by participants, such as humanism, communication, accountability, and ethics (Figure 3).

Discussion

Although medical professionalism is a goal which medical educators pursue in earnest, the process of identifying the sources and context of objectives has seldom been explored. Sociologists observing the "professionalism movement" are challenging medical educators to pause and reflect on (1) who determines the concepts and attributes of professionalism and (2) the processes by which these values emerge.[16]

To carefully address the element of who determines the concepts and attributes of professionalism, we invited more stakeholders than did previous studies to participate in the process of defining professionalism for our institution. In the medical education literature, previous definitions of professionalism derive mainly from doctors,[5,6,34] although some studies involved patients,[35–37] students,[35] and residents.[36] Only a few studies included nurses.[37] Our study included physicians at different stages of training, various types of allied health professionals, and members of the public who are not patients but have frequent interaction with patients and the medical professionals.

Considering the process by which professionalism values emerge, this method addresses the limitations of previous focus group studies[35–37] because NGT has been shown to reduce problems associated with traditional group discussions by limiting the effect of dominating personalities and ensuring the elicitation of all ideas and votes. These features of the NGT are particularly useful in cultural settings, like Taiwan, where seniority and authority are emphasized. Indeed, Cruess et al[38] warn of the danger of consensus methodology, noting the tendency to use focus groups among medical educators to promote buy-in. Cruess et al also suggest that the medical profession alone cannot define medical professionalism and posit that such processes require some familiarity with the literature in order to avoid "important omissions or an unbalanced definition." Our process was devised to avoid these pitfalls both by constructing a basic framework informed by the literature and by including nonmedical participants in the process.

In an earlier focus group study, Wagner et al[36] identified patient relationships, knowledge, technical skills, and character virtues as the primary themes of medical professionalism. These items are recognized in our NGT study and parallel the three fundamental steps in the NTUCM professionalism framework. However, humanism and social accountability, which are key components of professionalism in the literature, were not explicitly discussed by Wagner. These items were deemed crucial by our participants, and humanism received significant votes in our NGT groups. This might reflect the advantage of NGT over the usual focus group method.

In addition to the benefits of advancing the methods of generating a general professionalism framework, another strength of this study is to challenge the uncritical adoption of Western professionalism frameworks in non-Western settings. At first glance, our framework shares some similarities with its Western counterparts. Clinical competence, communication, and ethics are the foundational steps on which medical professionalism is built. The four pillars of humanism, excellence, accountability, and altruism are the core—supportive principles to be wisely applied to medical practice. It is possible to reorder the steps and pillars according to perceived importance, but the committee agreed that the items placed on the steps are foundational to learning and practicing medicine and that the items in the pillars represent aspirations for effective professional physicians (Figure 1).

The most striking difference between the NTUCM framework and Stern's framework is the consensus among our expert committee to ensure the addition of "integrity" as the beam capping the four pillars. Whereas Western frameworks based on the Hippocratic tradition stress the primacy of patients, the Confucian tradition of Taiwan emphasizes that one should become a person with integrity in order to serve others. Confucius[39] wrote, "The virtuous man, in the world, does not set his mind either for anything, or against anything; what is right he will follow." Similar to Western philosophies of virtue ethics, Confucians believe that people with integrity will make ethical choices even under temptation and confusion. The expert committee placed the concept of integrity centrally in our framework because the Confucian tradition is more powerful than the Hippocratic tradition

Figure 2 Characteristics of professionalism identified by 91 participants in nominal group technique exercises taking place in 2008–2009, mapped onto National Taiwan University College of Medicine's framework for medical professionalism. A darker background indicates a higher percentage of participants identifying the attribute as important. Adapted from Stern DT. Measuring Medical Professionalism. New York, NY: Oxford University Press; 2005. By permission of Oxford University Press, Inc. (www.oup.com).
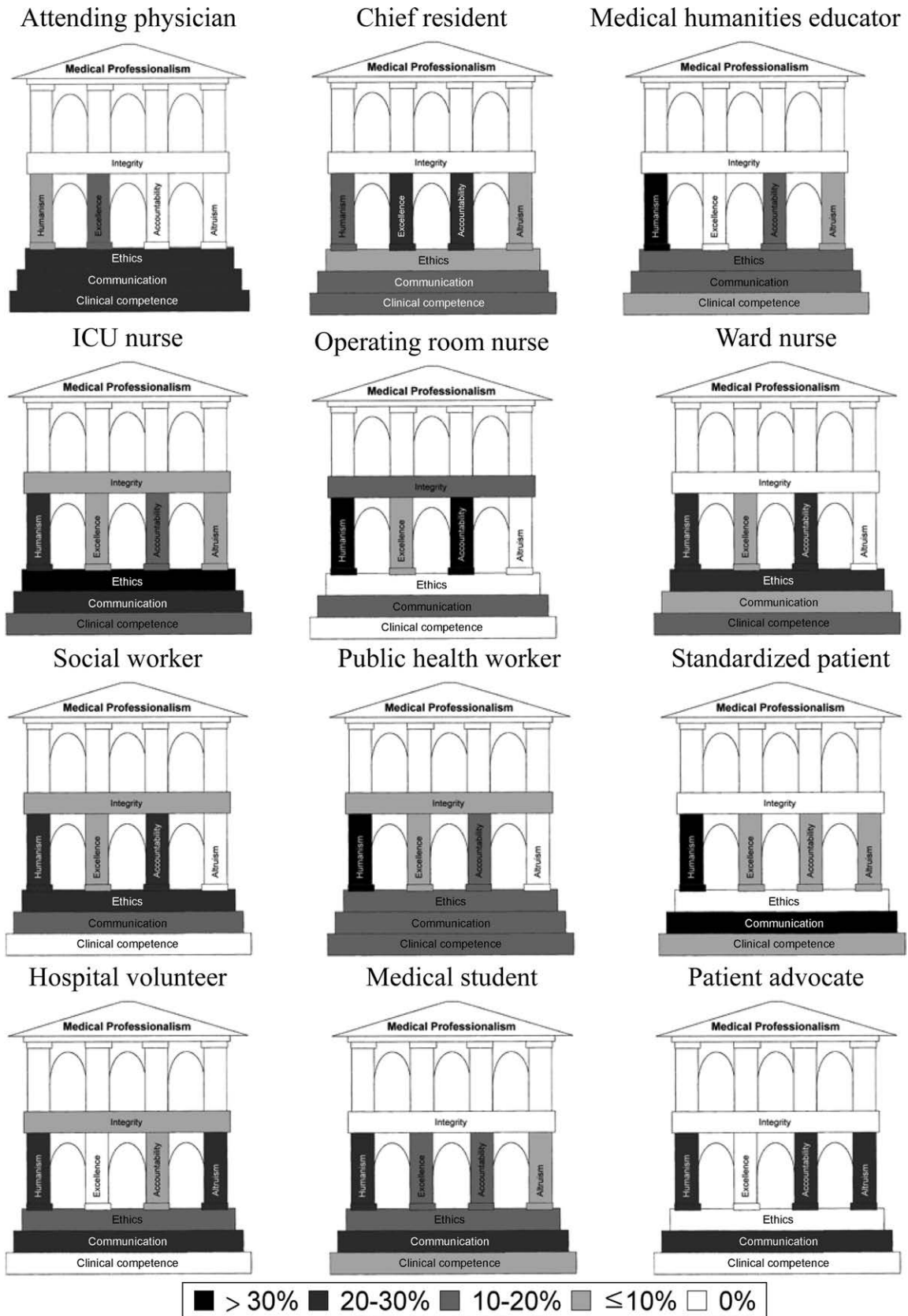
Figure 3 Aggregated characteristics of professionalism identified by 91 participants in 12 groups during nominal group technique exercises taking place in 2008–2009, mapped onto National Taiwan University College of Medicine's framework for medical professionalism. A darker background indicates a higher percentage of participants identifying the attribute as important. Adapted from Stern DT. Measuring Medical Professionalism. New York, NY: Oxford University Press; 2005. By permission of Oxford University Press, Inc. (www.oup.com).
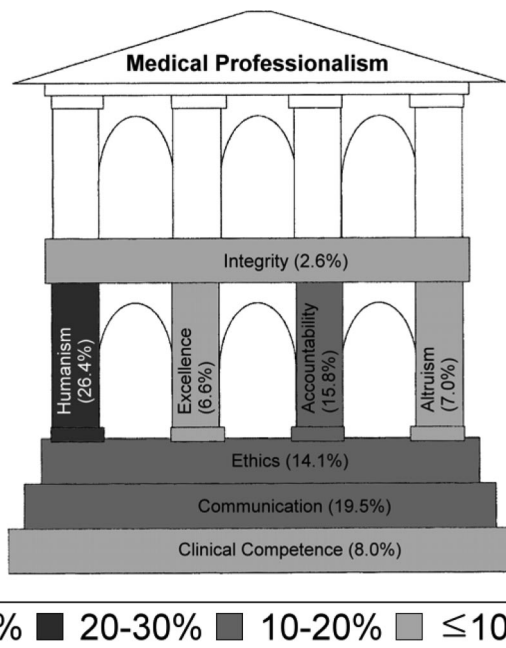
in the Taiwanese context. This framing reminds us that the cultivation of integrity would guide us to choose the right path and to harmonize potential conflicts.

Although NTUCM's framework for medical professionalism addressed most of the items identified in the development process, a few items raised by some NGT groups were not easily incorporated. These items did not fit in the category of humanism, which denotes a sincere concern for others, and were instead concerned with the balance between physicians' personal and professional lives. For example, participants listed managing time for family and self, healthy lifestyle, recreation, and self-care. Whereas Western professionalism frameworks emphasize the primacy of patients and separate physicians' professional and personal lives, Confucian cultural traditions support the harmony of these roles.

In Confucian thinking, the position of the self is inseparable from, if not dependent on, one's social roles. Thus, we created a "living framework" that accounts for individual as well as professional values. We designed our professionalism framework intentionally to include empty space, which acknowledges personal responsibility in addition to social responsibility. The presence of flexible space amidst the otherwise structured scheme signifies the reality that a physician's professionalism is both grounded and dynamic—based on core principles defined by society, but also responsive to personal growth over time.

Multiple items categorized into the eight-competency framework align with deep cultural meanings in Taiwan. For example, we categorized the concept of *zi zhong* (conducting oneself with dignity) into "integrity." *Zi zhong* has a long tradition in Chinese culture. In traditional Chinese culture, it is widely accepted that to be self-dignified or self-respecting is one of the first steps toward becoming a Confucian scholar or official. Literature dating back 2,000 years articulates the importance of *zi zhong* as a virtue of a government official, because of its effect on the well-being of laypeople and the prosperity of the country.[40] This concept, also raised by the NGT participants, is deep-rooted in our culture and carries more weight than "integrity" as it is described in existing Western professionalism literature.[1–7,33–38] We plan to conduct further research to

investigate the complex relationship between existing professionalism frameworks and Confucian values. It would be interesting to conduct comparative studies applying similar methods in other non-Western countries where the influence of Western medicine is less prominent than in Taiwan. To our knowledge, and according to an international working group's discourse analysis,[17] there are no studies reporting non-Western models of medical professionalism other than a Japanese study which found a professionalism mini-CEX exercise reliable and valid but added four more culturally relevant items.[15]

After constructing NTUCM's framework for professionalism, we took several steps to promote the core values of our framework at our institution. Curriculum planners addressed the calling for greater clinical competence and excellence by more carefully integrating these competencies into existing curricular structures. To address humanism and communication, we revised the courses of the first two years substantially, especially courses in liberal arts and medical humanities. As for ethics, accountability, altruism, and integrity, our institutional leaders placed an emphasis on addressing the "hidden curriculum."[41,42] As examples, the institution supported awards for altruism and promoted essay contests surrounding appreciative inquiry.

In concert with these curricular and extracurricular changes, student committees actively promoted professionalism. One example is a student-initiated self-study to examine both formal and informal curricula. That faculty members, support staff, and students readily accepted these measures suggests that our process and resulting framework reflected the values of our stakeholders. In contrast, a previous effort to adopt a Western framework of professionalism at our teaching hospital was not well received by teachers or students. As Cruess et al[43] suggest, "when professionalism is taught, it should be related to the different cultures and social contracts, respecting local customs and values."

A limitation of this study is that we only ran one NGT meeting for each group. Ideally, we would continue holding NGT meetings for each occupational group

until the data reached saturation—that is, until no more new attributes were identified by new NGT groups. Another limitation of this study is that the nonmedical participants (medical humanities educator, standardized patient, hospital volunteer, and patient advocate) might be so involved with medical professionals that their views about the ideal doctor might differ from those of the general public, which defines the society's contract with the medical profession. Although our study involved patient advocates who have a deep understanding of the medical needs of the general public, further studies with more NGT participants would address these limitations.

In conclusion, this study challenges the universal applicability of the Western frameworks of medical professionalism and proposes a process to build a professionalism framework that reflects the cultural heritage and the values of local stakeholders. We found it was worthwhile and rewarding for our institution to search for a professionalism framework reflecting our cultural heritage and the values of the stakeholders. Other institutions may adopt the approach described in this report to promote a framework of professionalism that fits their institutional values and traditions.

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Perspective: Can Emotional Intelligence Training Serve as an Alternative Approach to Teaching Professionalism to Residents?

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Abstract

Of the Accreditation Council for Graduate Medical Education's six general competencies, professionalism has posed the greatest challenges for medical educators to define and teach. Currently, professionalism is largely taught experientially through role modeling, which has many shortcomings as a sole teaching strategy. Namely, role modeling does not involve an explicit curriculum, the skill is difficult to teach or develop, and physicians may be reluctant to talk about lapses in their own behaviors regarding professionalism.

In this article, the authors propose instead using the model of emotional intelligence (EI) to define key elements of professionalism and as the basis for their proposed curriculum for teaching professionalism. EI is a well-developed construct and consists of four types of abilities: emotional self-awareness, self-management, social awareness, and relationship management. EI is grounded in effective performance and leadership success rather than in moral right or wrong.

The authors propose that the EI abilities suggest specific curricula which, when

successfully taught by faculty and learned by physicians-in-training, would allow trainees' professionalism to be recognized and measured in ways that are not currently possible with existing hidden curricula. The authors hope that those who develop policies regarding professionalism and those who train physicians will find this construct a useful way of developing curricula for the critical professionalism competency.

In changing graduate medical education (GME) accreditation standards in 1999 from documentation of rotation objectives and the number of hours spent in each rotation to a competency-based assessment system,[1] the Accreditation Council for Graduate Medical Education (ACGME) Outcome Project introduced six general competencies—patient care, medical knowledge, interpersonal and communication skills, professionalism, systems-based practice, and practice-based learning and improvement—on which residents and residency programs would be assessed. Among these

six competencies, patient care and medical knowledge have seemed to be straightforward as metrics, whereas the other four—particularly professionalism—have posed greater challenges for measuring progress and for developing curricula.

In this article, we underscore the limitations of using role modeling as a primary method for teaching professionalism to physicians-in-training and propose that emotional intelligence (EI)[2,3] training satisfies proposed criteria for the professionalism competency.[4] We conclude by offering a curriculum design to develop EI competencies that could also develop professional behaviors in trainees.

The Challenge of Defining and Teaching Professionalism

The early scholarly response to the ACGME's launch of the professionalism competency was to invoke classical works in search of a definition. Early examination of professionalism through the lens of the social contract[5–7] defined *professionalism* using a set of other abstract concepts (e.g., respect, altruism, compassion). As the challenge of defining *professionalism* continues,[8–10] medical educators must determine whether professionalism is the act of behaving

morally or, as intended by the authors of the Outcome Project, a competency that includes a cognitive knowledge base and a set of developmental skills.[11] Huddle[12] suggested that professionalism includes both a cognitive knowledge base (e.g., of medical ethics) and a moral behavior base that is gained over a lifetime rather than in the short term. Professionalism, therefore, requires not only that medical students and residents know the right thing to do (cognitive aspect) but that they actually *do* the right thing, even in the most challenging of circumstances (moral aspect).

Cruess and Cruess[13] suggested that professionalism curricula should include explicit cognitive, experiential, and role modeling experiences. In our review of the literature, we found examples of formal didactic curricula that include medical ethics, teaching of professional principles, small-group sessions on "professional topics" guided by mentors, and opportunities for action and reflection.[14–16] Doukas[16] noted, however, that although formal instruction in bioethics could help residents develop their professionalism, residents are most likely to learn "virtue ethics" through the informal experience of modeling their own behavior after that of their clinical teachers. This phenomenon of learning

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through informal experience has been called medicine's "hidden curriculum."[17]

Whereas effective role modeling is a key competency for educators,[18] teaching the morality-based component of professionalism through a hidden curriculum poses challenges. The hidden curriculum relies on medical students' and residents' observing the everyday behaviors of senior physicians, analyzing the observed behaviors in the context of their own behaviors, and ultimately knowing when they should incorporate the observed behaviors into their own work. This informal role modeling lacks an associated measurable outcome and only shows the learner the mentor's actual behavior—not the mentor's internal, private analysis of the features to model. Furthermore, the mentor's internal analysis may not include all aspects of professionalism, and he or she is unlikely to communicate to the learner how to make difficult choices between competing goals, which is the essence of professionalism.

Consider the common scenario of a senior resident who, during her 29th hour of consecutive service, is at the bedside of an acutely deteriorating patient. The senior resident must choose between leaving the hospital (to remain in compliance with current duty hours rules) and staying with the patient (to provide optimal care while arranging a care transition). In role modeling this scenario for an intern, the senior resident shows the intern her final decision but not the reasoning that informed her behavior. Said differently, the intern sees the senior resident doing what the

resident determines is the "right" thing to do, but he does not learn the full, professional lesson of balancing values. Another shortcoming of teaching professionalism via the hidden curriculum is that the busy intern could be absorbed in his own workload, not notice the senior resident's behaviors, and miss the learning opportunity entirely.

Another concern about depending on role modeling is that attending physicians may be hesitant to discuss professionalism—especially breaches of professionalism. In a recent qualitative study by Bryden and colleagues,[19] one participant statement summed up this issue: "I don't think there is a forum where people can discuss these things [breaches in professionalism] that they don't feel judged. I don't know how you do that." In the face of such reluctance to discuss professionalism, relying on role modeling seems inadequate. Educators must develop an alternative, better model from which to teach this critical competency.

Teaching EI as an Alternative Approach to Teaching Professionalism

Although attending physicians' role modeling of ethical, virtuous behavior will always influence trainees' development, role modeling unavoidably resists replication or being systematically taught. Thus, we submit that teaching the abilities that constitute EI represents a useful, alternative approach in teaching professionalism. EI offers a teaching

method that is explicit, is clear, and has rigor, thereby avoiding the shortcomings of the hidden curriculum of role modeling. To develop this suggestion, we first briefly review the concept of EI and then propose a model and framework for an EI curriculum that may also develop trainees' professionalism.

An overview of EI

EI[2,3] is a construct that has been associated with leadership success and consists of four types of abilities: emotional self-awareness, self-management, social awareness, and relationship management (Chart 1). Simply put, if you possess characteristics of EI, you are aware of your emotions, able to manage these emotions, aware of the dynamics of relationships, and able to manage yourself in service to enhancing group effectiveness.[2,3] EI is grounded in "effective performance" and leadership success[20] rather than in moral right or wrong. For example, Arora and colleagues[21] reported that high levels of EI positively contributed "to doctor–patient relationship, team-work and communication skills, and increased empathy." Lobas,[20] interviewing 10 chairs of academic internal medicine departments regarding the factors most associated with their professional successes and failures, identified having EI as the most important competency associated with success and lacking EI as being most closely associated with performance shortfalls. There is debate as to whether EI merely reflects fixed personality traits[22] or is a mixed model of abilities and personality traits. To date, there is substantial evidence that EI measures abilities, independent of personality traits, that affect performance.[23] Furthermore, EI abilities can be taught and sustained over time.[24]

Are EI and professionalism the same? There seems to be much overlap. As we note above, the behaviors often cited as manifestations of professionalism are the behaviors taught in EI training. Professionalism is a complex concept that includes cognitive, skill-based, and affective components. Simply, medical educators would like professionalism training to teach students and residents to do the "right" thing. On a morality-based platform, the right thing is grounded in a set of rules by which individuals are taught to live (though these rules change from culture to

Chart 1
Emotional Intelligence's Four Abilities and Their Associated Skills*

Personal competence	Social competence
Quadrant 1: Self-awareness	**Quadrant 3: Social awareness**
• Emotional self-awareness • Accurate self-assessment • Self-confidence	• Empathy • Organizational awareness • Service orientation
Quadrant 2: Self-management	**Quadrant 4: Relationship management**
• Emotional self-control • Transparency • Adaptability • Achievement orientation • Initiative • Optimism	• Developing others • Inspirational leadership • Influence • Teamwork and collaboration • Change catalyst • Conflict resolution

* Emotional competency inventory (ECI), copyright © 2002, developed by D. Goleman, R. Boyatzis, and Hay Group. Adapted with permission from Hay Group Inc.

culture). From an EI perspective, the right thing is grounded in striving for self-awareness and social awareness and using reflections to create effective personal interactions. The outcomes may be remarkably similar even as the journey to achievement may be different.

A framework for using EI to teach professionalism

The four types of EI abilities (Chart 1)[2,3] can each be divided into component skills that help learners develop and improve their EI. The two types of abilities on the left (in quadrants 1 and 2) relate to personal skills, and the two types on the right (in quadrants 3 and 4) pertain to social relationship skills. For example, through reflection, a resident may come to recognize that his emotional response to being time pressured is to become short tempered or frustrated (self-awareness, quadrant 1). Once he has identified this emotional response, the resident can learn to manage it internally or can learn skills to improve his efficiency (self-management, quadrant 2). Similarly, a resident who learns about the values and cultural background of her patient may better understand the patient's response to the disease and/or therapies (social awareness, quadrant 3). Further, the resident may use such knowledge to improve her patient's ability to both cope with the disease and comply with the therapy (relationship management, quadrant 4).

As illustrated in Chart 1's four quadrants, this model encompasses abilities that are traditionally associated with professionalism. For graduate medical educators, this model provides a framework to teach professionalism to physicians-in-training. In each quadrant in Chart 2, we propose topics that, together, would make up a professionalism curriculum. For example, an important part of managing relationships is learning how to manage and resolve conflict effectively. Thus, teaching trainees how to manage conflict (quadrant 4) would enhance their professionalism.

Although reference in the literature to training in EI abilities as part of a medical school professionalism curriculum is rare, there are scattered reports of needs analyses and task force reports of models that are either under consideration or in progress as pilot projects.[25,26] In general, these models support annual or semiannual workshops, weekly or monthly seminar series, community service experiences or externships, or a combination of these components. Most important, it is clear that many academic institutions are debating how to implement a professionalism curriculum, so an EI model such as the one we propose here may offer a useful construct.

A formal EI curriculum to teach professionalism, as outlined in Chart 2, offers several advantages. First, it defines specific skills that are the basic tenets of

real-world professional behavior for successful physicians. In the scenario of the resident who understands her patient's cultural background, faculty could measure the patient's compliance with therapy and clinical outcomes as a reflection of the resident's EI, invoking the principle that good doctors tend to have good patient outcomes. Second, the concepts of EI provide a nonjudgmental vocabulary that educators could use to discuss professionalism in physicians-in-training. For example, rather than focusing on changing a resident's personality, an EI-based curriculum to enhance teamwork would focus on specific behaviors that the resident could develop or enhance to promote team membership. In this way, the faculty would measure and value the final team outcome rather than the resident's emotional feelings toward the team. Finally, there are well-developed, validated instruments to assess EI, so a resident's ability to learn and use this knowledge is measurable over the course of training. Program directors have access to a suite of instruments to measure progress, including ability measures such as the Mayer–Salovey–Caruso Emotional Intelligence Test,[27] self-reported measures such as the Emotional Intelligence Inventory,[28] and 360-degree measures such as the Emotional Intelligence Appraisal.[29]

Challenges and Conclusions

Our enthusiasm for introducing EI as an alternative approach to teaching professionalism is tempered by our recognition of potential challenges. First, faculty and learners must become familiar with the concepts and vocabulary of EI. Second, training in EI requires reflection on personal responses to internal emotions and attention to the reactions of others. Sincere personal reflection and attention take time and practice as well as a safe environment in which to share and discuss reflections. Third, time is at a premium in medical school and residency, and EI training could become an ineffective addition to an already-demanding curriculum. Administrators and faculty must keep this in mind when developing and implementing a new EI curriculum. Experience with including EI training in leadership development programs for faculty has been reported[30] and has since been extended to trainees, thereby

Chart 2

Proposed Curricular Elements for Teaching Professionalism Using the Emotional Intelligence Model*

Quadrant 1: **Enhancing your personal discovery**	**Quadrant 3:** **Enhancing your awareness of groups**
• Meyers–Briggs Type Indicator • 360° feedback • Learning styles inventory • Identifying your ideal self	• Active listening • Empathy • Cultural competence • Systems thinking
Quadrant 2: **Enhancing your ability to manage yourself**	**Quadrant 4:** **Enhancing your ability to manage relationships**
• Time management • Communicating with patients • Communicating with groups • Coping strategies • Stress management • Developing a vision for yourself	• Team building • Conflict resolution • Creative problem solving • Change management

* The heading within each quadrant is the title of a proposed course to address the corresponding specific element of emotional intelligence (see Chart 1). The bulleted items identify some specific competencies and curriculum components for the proposed course.

providing examples of effective integration of EI training in other domains.

These potential challenges notwithstanding, we maintain that the concept of EI has value for teaching professionalism to physicians-in-training. The abilities that constitute EI can help define specific curricula which, when successfully taught to and learned by physicians-in-training, would allow professionalism to be recognized and measured in ways that are not currently possible in existing hidden curricula. Our hope is that colleagues who develop policies regarding professionalism and who train physicians will find this construct helpful and will consider learning more about EI and incorporating EI training into curricula for professionalism.

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Perspective: **Organizational Professionalism: Relevant Competencies and Behaviors**

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Abstract

The professionalism behaviors of physicians have been extensively discussed and defined; however, the professionalism behaviors of health care organizations have not been systemically categorized or described. Defining organizational professionalism is important because the behaviors of a health care organization may substantially impact the behaviors of physicians and others within the organization as well as other institutions and the larger community. In this article, the authors discuss the following competencies of organizational professionalism, derived from ethical values: service, respect, fairness, integrity, accountability, mindfulness, and self-motivation. How nonprofit health care organizations can translate these competencies into behaviors is described. For example, incorporating metrics of population health into assessments of corporate success may increase collaboration among regional health care organizations while also benefiting the community. The unique responsibilities of leadership to model these competencies, promote them in the community, and develop relevant organizational strategies are clarified. These obligations elevate the importance of the executive leadership's capacity for self-reflection and the governing boards' responsibility for mapping operational activities to organizational mission. Lastly, the authors consider how medical organizations are currently addressing professionalism challenges. In an environment made turbulent by regulatory change and financial constraints, achieving proficiency in professionalism competencies can assist nonprofit health care organizations to promote population health and the well-being of their workforces.

Recent discussions of medical professionalism have enumerated important physician competencies,[1] described how unprofessional behavior endures throughout a physician's career,[2] and, most recently, emphasized how the systems in which physicians practice influence their behavior.[3–5] Less has been written about the professional behaviors of those systems themselves, with the exception of their management of conflicts of interest.[6] Others have described the regulation of health care organizations' market behaviors[7] or how organizations can negotiate contemporary ethical

challenges by using professionalism as a guide.[8] Lesser and colleagues[5] have used the Physician Charter on Medical Professionalism to describe how both individual physicians and organizations can promote professionalism using a systems framework. However, we are not aware of any comprehensive framework of professionalism competencies *for organizations*. If there is a bidirectional influence between health care systems and the professionals who work within them, in order to maximize the professionalism of both, it will be important to answer the question, "What are the professional competencies of health care organizations?"

The answer to this question is important to nonprofit, tax-exempt health care organizations for several reasons. First, these organizations are perceived as the face of the profession by patients and the public at large. They must therefore reflect accurately the values of the profession. Second, the very nature of their tax-exempt status requires them to relate positively to society. Eligibility for this status requires that they be organized and operated exclusively to promote specific purposes, which include charitable, religious, educational, and scientific ends.[9] Finally, a number of organizations, such as the Joint Commission and

the National Committee for Quality Assurance, are scrutinizing the behavior of such nonprofits, looking for deviations from and compliance with professional standards.

In this article, we propose to clarify what constitute the professional competencies of nonprofit health care organizations and describe related behaviors. For the purposes of this article, a nonprofit health care organization is any nonprofit organization that *provides goods or services to patients or health care professionals*. Many of the competencies we will discuss are applicable to both for-profit and nonprofit organizations because they promote managerial and financial success. Nevertheless, we have chosen to focus on the nonprofit world because for-profit organizations' responsibility to their shareholders may trump other considerations.

Because professionalism is rooted in ethical foundations, we begin with ethical values. Although the choice of ethical values may seem arbitrary, we have reviewed publications featuring medical ethics and professionalism[10,11] and selected those values we deemed most relevant to the delivery of health care by organizations. Translating those values into behaviors requires developing

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specific competencies, which we define as that combination of knowledge, skills, and abilities that creates the capacity for performance. Rather than exhaustively enumerating them, we will explore those behaviors we deem most relevant to the current transformation of American health care (see Chart 1). We will first describe how professionalism competencies derived from ethical values can serve as organizing principles for behaviors, both inside health care organizations and in a broader community and social context. We then describe the unique competencies of leadership provided by both the management and governance structures of the organization. Lastly, we will examine how health care organizations are currently addressing professionalism challenges.

Competencies: The Link Between Values and Behaviors

Service

Service to the patient and society is the raison d'être of medicine and, therefore, of the nonprofit health care community. This competency is derived from the ethical value of beneficence, or actions promoting the well-being of others. Although the focus of the medical profession is health, service for nonprofit health care entities can include educational and scientific activities in addition to the provision of care for the indigent.

The World Health Organization's definition of health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[12] This definition suggests that many dimensions of community life, such as education, basic sanitation, and crime, influence the health of a population. Because some of these factors overlap the purview of government, each health care organization must determine which of its activities intersect with this seemingly broad definition. Regardless, such a conceptualization implies that an organization's obligations extend beyond the individuals encountered within its walls to the larger community within its sphere of influence. This awareness reveals opportunities for occasionally competing organizations to collaborate for the common good. For example, competing organizations might duplicate one another's expensive, revenue-generating services such as interventional cardiology or oncology treatment centers instead of providing less lucrative ones such as mental health services, thus shortchanging the community. Promoting health includes minimizing harm, a sometimes-unintended consequence of health care delivery. For example, health care delivery systems should mitigate the environmental impact of their paper, biological, and toxic waste.

Externally, the service competency is demonstrated by incorporating indices of community health into the decision-making process for organizational initiatives. It is known that a lack of availability of mental health and primary care services is reflected in the number of uncompensated emergency room visits, whereas an organization's efforts to improve wellness are manifested by a healthy built environment and safety net clinics. Improvement in both might be measured by a decreased prevalence of obesity and smoking and by lower infant mortality rates. Subsequently, the organization would monitor how its strategic initiatives impact the health of the community and would negotiate tensions between the two. Although

Chart 1

Derivation of Organizational Competencies and Behaviors From Ethical Values*

Value $\longrightarrow$	Professionalism Competency $\longrightarrow$	Behaviors
Beneficence (does good, acts with generosity and kindness)	• Service (to the patient, the community, and the profession)	• Promotes population health • Reduces harm • Promotes well-being • Aspires to improve the organization and the profession
Dignity (respects self, is worthy of esteem)	• Respect (for self, patients, and employees)	• Responds to regular assessments of the experiences of patients and employees • Provides access to care • Supports teamwork • Promotes cultural sensitivity • Rewards achievement
Justice (is impartial, upholds the laws)	• Fairness	• Practices and promotes ethical stewardship of resources • Incorporates voice of community • Advocates equitable payment policy • Reduces disparities
Honesty (is morally upright, truthful, and candid)	• Integrity • Accountability	• Practices transparency • Discloses meaningful performance information • Eliminates conflicts of interest
Self-discipline	• Mindfulness • Self-motivation	• Engages in collective self-reflection • Closes the gap between current performance and the ideal state • Utilizes supportive structures, e.g., ethics committees, quality improvement committees

*Developed by the authors as a way for nonprofit health care leaders to best improve the professionalism of their organizations.

the presence of laypeople on boards of directors or planning committees may improve public relations and expand the discourse within an organization, alone it is insufficient to meet community health needs. As accountable care organizations grapple with community issues that impact population health, they may need to employ novel social science technologies. For example, they may need to design approaches that impact those who, for ethnic, social, financial, or emotional reasons, are isolated from traditional health care institutions or those who seek care within an alternative health care setting.[13]

These service-oriented behaviors reflect the organization's aspiration to uphold the standards of the profession as expressed by credentialing organizations and quality improvement groups, such as the Institute for Healthcare Improvement and Leapfrog. Organizations committed to service excellence also improve the profession by participating in such groups' projects and entering related performance data into regional and national databases.

Because individual health and organizational health are interrelated, service extends internally to employees. Organizations should monitor the well-being of their employees and provide resources both to improve their general health and to relieve those who suffer disproportionately. Because those with impaired well-being or disruptive behavior affect other individuals and an organization's ability to achieve its goals,[14,15] the organization must enforce standards for behavior and provide resources for those who struggle. A business case can be made for practices that balance productivity expectations with concern for employees' well-being.[16] These practices promote loyalty, minimize turnover, and create a more positive experience for customers and patients.

Respect

Respect is derived from the ethical value of dignity. This competency esteems all voices by creating a forum for those who may struggle to be heard. Because personhood, not expertise, is the only prerequisite for respect, it reorders traditional power relationships within medical institutions. Patients and employees at all levels are as deserving of

respect as physicians and chief executive officers. Respectful practices throughout an organization support the emerging dynamics of teamwork and promote cultural sensitivity.[17]

Internally, respect incorporates the voice of employees in organizational initiatives and rewards achievement by whatever metrics apply to a particular job. Similarly, respect incorporates the voice of the patient in clinical domains, perhaps on rounds or on relevant quality improvement committees. Such humanism in a social context leads to the next competency.

Fairness

Fairness derives from the value of justice. This competency acknowledges that resources are limited and that the health of the nation depends on the ability of all citizens to meaningfully access quality health care, although a sometimes-messy political process determines how society ultimately distributes public and private dollars toward that end. Various mechanisms at the governmental, organizational, and individual levels restrain exploitation of limited resources by the powerful few.

As the nation reconfigures the health care delivery system with the goal of maximizing value, the behaviors of organizations will be important because organizations can more effectively impact the health of communities and populations than can individual physicians. Improved community health can be consistent with reduced expenditures at both a societal and organizational level. For example, rather than each health care delivery system seeking solely to maximize its own resources through competition, a region would benefit from collaboration amongst institutions to decide how they can provide the highest level of quality and efficiency together. Similarly, when institutions are financially burdened by the uninsured or mentally ill, they would benefit from coordinating safety net clinics to prevent such patients' using more expensive services. Regionally, such cooperation reduces disparities in health. Collective advocacy by professional organizations can lead to an equitable payment policy that meets the nation's increasing need for primary and geriatric care.

We believe that practicing fairness in the community is not possible without first

examining the roles of hierarchy and power inside an organization (which we will discuss further below). A well-functioning professional organization exhibits a culture that recognizes the equal value of each human being and the critical contribution of each position, despite deserved differences in compensation based on skill, training, and levels of responsibility.

Integrity and accountability

Integrity and accountability derive from the value of honesty and make fairness apparent to others. A commitment to such transparency means that when information is useful and meaningful to stakeholders, it will be disclosed.[18] The challenge, of course, is when such disclosure compromises an organization's self-interest. We believe that withholding proprietary information is justifiable if sharing it could compromise competitiveness but would not benefit patients. Withholding information of potential benefit to patients or employees out of self-interest is not justifiable. Transparency includes making internal processes and outcomes apparent to all concerned. This starts with explicit disclosure of the metrics an organization uses to measure success. When errors occur, they should be promptly disclosed.

Accountability requires acceptance of responsibility for error and correcting the approach that led to it. Performance should be measured against commonly accepted standards of achievement. When discrepancies exist, the organization should strive to improve performance and eliminate deficiencies or shortcomings. Organizations should divest themselves of financial and other conflicts of interest. When divestment is a disadvantage to the patient, we believe benefit to the patient should be used as the metric to guide resolution of such conflict.

Mindfulness and self-motivation

Mindfulness and self-motivation are derived from the value of self-discipline. Successful execution of all the other competencies depends on self-awareness and a desire to close the gap between the current and ideal state. Developing mindfulness, or "awareness of self in the present moment," has been shown to help high-reliability organizations, such as nuclear power plants and space shuttles, successfully manage unforeseen

events.[19] Both for-profit and nonprofit health care organizations often confront unforeseen emergencies with high-stakes outcomes. Cultivating mindfulness by the organization and by individual staff members would help them "handle unforeseen situations in ways that forestall unintended consequences."[20] In addition, for organizations to "do good" (beneficence) as well as avoid harm, they must monitor their impact on others and use external benchmarks for assessment.

Responsibility of Leadership

Nonprofit leadership provides the direction of the organization and, therefore, is responsible for seeing that organizational behavior is aligned with the principles discussed above. Leadership is the responsibility of both the governance (e.g., board of directors) and management (e.g., chief executive officer). The Healthcare Leadership Alliance definition of the professionalism competency for leaders is "the ability to align personal and organizational conduct with ethical and professional standards that include a responsibility to the patient and community, a service orientation, and a commitment to lifelong learning and improvement."[21] We propose that through combining the five ethically based competencies we have discussed above, leaders can best improve the professionalism of nonprofit health care organizations.

Service

Leaders are ultimately responsible for balancing bottom-line considerations with the principles of organizational professionalism. As such, they must maintain and demonstrate high ethical and professional standards. Leadership should identify or construct metrics for employee and community health and implement relevant policies. They should seek efficiencies by collaborating with other organizations. Such dialogues on a larger scale raise the consciousness of the entire population regarding the interrelatedness of individual and corporate activities.

Respect

Leaders must treat all people—patients and employees alike—with equal respect, regardless of their position, education, experience, or social background.

Therefore, leadership should create policies that institutionalize such equal treatment and educational initiatives to overcome preexisting cultural biases. Diversity, by increasing the heterogeneity of a workforce, increases its flexibility and capacity to surmount complex organizational challenges.[22] An important leadership task is to articulate organizational values and goals with language that engages diverse stakeholders.[23]

Fairness

When leaders allocate resources disproportionately, the strategic imperatives underpinning such decisions should be made explicit; otherwise, they risk losing the support of those who feel deprived of "their fair share." Selective enforcement of policies, such as when leaders tolerate disruptive behavior by high producers, undermines trust in leadership and threatens organizational cohesion. In contrast, fair treatment of employees encourages their fair treatment of customers, thus fostering a professional culture.

Integrity and accountability

Leaders must understand their responsibilities both personally and to the organization regarding conflicts of interest. Although it will not be possible to eliminate all such conflicts, we believe that should be the goal, with transparent management for those conflicts that remain.

Mindfulness and self-motivation

Whereas managers and employees may appropriately focus on particular tasks or challenges, an organization's leaders must appraise how well routine activities reflect organizational values. Organizations struggle daily to align tactical and productivity goals with professionalism. Leadership is the conscience of an organization, which demands great courage. At some point in the evolution of most organizations, fearful voices will frame ethics and competitiveness as an "either–or" choice. Creative leaders can demonstrate how this is a false dichotomy. We believe that maintaining a professional culture has great market and competitive value by attracting and retaining talented individuals and improving the quality of the work product.

Integrating the Five Competencies to Achieve Organizational Professionalism

Although we have, for clarity, discussed these capacities separately, their thoughtful, systematic integration into all operations of an organization will promote professionalism as an emergent quality of routine interactions. Mindfulness at the leadership level is the capacity to hold and balance all of these ideas simultaneously. An activity that increases accountability and alignment at all levels of organizational activity is the discipline of collective self-reflection,[24] in which leaders routinely ask such questions as "How well are we working together?" and "How well do our actions align with our mission and professional values?"

An important responsibility of any health care organization's leadership is to project this integrated vision externally, to convey how the organization's values connect with those of the larger society. Because the allegiance of professionals tends to be stronger to their own professions than to their organization,[22] this articulation of organizational vision can create an important alliance between health care professionals and administrators, who might otherwise deride each other's lack of concern, or preoccupation with financial considerations, respectively.

Blackmer[8] outlines four strategies to reinforce the ethical foundations of a medical organization. These are "Conducting a formal process to clarify and articulate the organization's values …, facilitating … learning about ethics and professionalism …, creating structures that encourage and support the culture …, [and] creating processes to monitor and offer feedback on ethical performance…."

We believe the intricate mix of nonprofessionals and diverse professionals within health care organizations is unlikely to support a monolithic local vision of how social goals should be achieved. Complexity theory suggests that an organization's identity is the culture that emerges from multiple conversations among its diverse members.[25] Although these conversations routinely transpire during the workday, separate facilitated conversations can create oases in daily routines that can

help leadership discern evolving internal challenges and their relationship to the organization's broader social context. Leaders can succeed in creating an ethical culture only insofar as they can create the vessel for its members to enact that ethical vision. To achieve this goal, leaders must maintain currency in the profession and exhibit the articulated expectations of conduct.

Discerning how to adapt professionalism principles to the culture and purpose of a particular nonprofit organization is a core task of leadership. Yet, providing a road map for implementing the behaviors we have described is beyond the scope of this paper. Organizations will take myriad paths. Established management principles will be generally applicable; unique circumstances will require imaginative adaptation.

Organizational Professionalism in the 21st Century

The daily experience of patients will reflect the professionalism of organizations more than their mission and vision statements. Those experiences will depend on an organization's culture more than its policies and procedures. Indeed, organizational culture may predict clinical outcomes better than evidence-based protocols and processes.[26]

How are organizations doing in dealing with these challenges? It seems unlikely that any organization will be able to embrace all of the behaviors that constitute professional behavior. Moreover, the challenges will be different for different members of the nonprofit medical world. Particularly troublesome for some organizations will be dealing with the provision of service to the community, conflicts of interest, self-discipline, transparency, and ethical stewardship of resources.

Service to the community, a requirement for the nation's roughly 2,900 nonprofit hospitals, was surveyed in 2009 by the Internal Revenue Service.[27] Hospitals spent an average of 2.5% of their total expenses (excluding bad debt) on providing charity care. This compares to the 5% figure proposed by Senator Chuck Grassley to define whether hospitals could claim exemption from taxes. On a more positive note, adding unreimbursed Medicaid expenses and

research, education, and the clinical expenses for which the provider takes a financial loss (all community benefits recognized by the federal government) to spending averages, the figure reaches 8.3%. Although the "correct" percentage remains undefined, it is of interest that of the hospitals providing an above-average amount of charity care, 75% turned a profit.

Issues related to conflicts of interest have been particularly vexing for physician membership organizations and academic medical centers. A 2008 Association of American Medical Colleges Task Force report signaled that many medical schools are adopting new policies that allow them to better manage and sometimes prohibit relationships with industry that create conflicts of interest that compromise professionalism.[28] Professional medical associations face a particularly difficult challenge. There have been some notable attempts to address conflicts and some successes, although no consensus has been reached about best practices.[29] Many would argue that physicians and other providers need such organizations to represent their political and economic interests and that such advocacy often improves patient care and the interests of patients. Perhaps the best way to deal with this conflict is to separate the responsibilities, with one group representing the economic and political interests of physicians and a second group representing the educational, professional, and patient-oriented interests. Above all, professional medical associations should, in the words of John Ring,[30] be "working for the good of our patients, rather than [as] a pressure group aiming for political power as a way to build organizational prominence, to create personal prestige, or to line our pockets."

The central element of self-governance is the requirement for self-discipline through policing and corrective or punitive actions. Physicians recognize their obligations and society's interest in being shielded from negligent and unethical practitioners. These tasks have been relegated to various accreditation, certification, and licensing bodies. For the year 2007, the Federation of State Medical Boards reported that 2,743 disciplinary actions against physicians were taken by the member U.S. boards.[31] This rate of 2.92 serious actions per

1,000 physicians has raised questions by some as to whether the profession has been complacent or simply too lenient in carrying out its obligations. The *Washington Post* reported that between 1999 and 2004, 972 physicians who had been disciplined in one state were able to continue to practice by relocating to another state.[32] Additionally, a report from *Health Matrix* by Jung and colleagues[33] indicated that 67% of those convicted for insurance fraud and 36% of those convicted in relation to misuse of controlled substances received only nonsevere penalties from their medical boards. At the core of this issue is the need for the profession to develop and implement a code of its own which constitutes a set of agreed-on shared values.

Medical professional organizations are beginning to deal with issues of transparency and accountability.[34] Implementing these principles should provide important tools to improve quality, safety, and outcomes and also to control costs. Currently, patients have little information to inform their choice of health care provider. There remain valid barriers including the fact that most publicly reported data are not statistically valid for ranking either physicians or hospitals.[35] Eventually, however, improving the reliability of data should allow patients to evaluate their options and, in the meantime, will assist them in managing and improving processes and outcomes. An example of the latter is the improvement by hospitals in evidence-based acute myocardial infarction management (88% in 2005 to 98% in 2010) resulting from eight years of data collection and six years of public reporting by the Joint Commission.[36]

Stewardship of medical resources will require a balance of what is best for the individual patient and what is best for society. Key to this effort will be for medical organizations to deal with the issues of disparities in care and of overuse. The issues of disparities are complex and will ultimately require the implementation of social policies well beyond the scope of activities of medical organizations. Current programs driven by the profession that should facilitate improvement include diversification of the workforce, teaching cultural competency, and development and

implementation of guidelines and public reporting of outcomes.[37,38] With regard to overuse of health care, an estimated $600–700 billion annual item,[39] again solutions are complex but include access to patient-centered primary care and the establishment of guidelines and publicly reported outcomes.

Closing Remarks

Medical professionalism has most often considered the behavior of individuals, less often the collective behavior of physicians. We believe that focusing on the professional behavior of medical organizations can be fruitful because they represent the effective link between individuals and society. Professional behavior at the societal level is challenging for both individual physicians and medical organizations: Individuals have little leverage to impact society; organizations are easily distracted by operational and business concerns. Because ethics-based entreaties risk dogmatism and irrelevancy, we have chosen to frame the discussion of organizational professionalism by translating traditional ethical values into contemporary organizational behaviors.

Just as personal well-being creates resiliency, organizational professionalism can establish homeostatic mechanisms that buffer internal and external stressors. Preventive efforts to create a self-regulatory culture can forestall the need to confront emergent threats. Unprofessional behaviors can then be normalized locally. The goals of creating attractive work environments and judiciously using resources can be accomplished by nonprofit health care organizations that are oriented toward the public good, mindful of each human interaction, and reliant on principles of professionalism to organize the intermediate processes.

The evolution of health care will be governed by three forces: professionalism, finance, and regulation. The proper role of regulation is to align the incentives of professionalism and finance to produce population health and a responsive, sustainable health care delivery system. The ethical foundation of professionalism serves as a powerful counterbalance to financial and political self-interest. Agreement to anchor future health system design and care delivery

on principles of professionalism can only benefit those who deliver and receive health care. There are increasing appeals for medicine to play a broader role in negotiating these forces,[40,41] and some imaginative approaches have emerged.[42,43] Failure of such efforts will inevitably result in more regulation; success will lead to renewed faith in medical professionalism.

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Perspective: **A Culture of Respect, Part 2: Creating a Culture of Respect**

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Abstract

Creating a culture of respect is the essential first step in a health care organization's journey to becoming a safe, high-reliability organization that provides a supportive and nurturing environment and a workplace that enables staff to engage wholeheartedly in their work. A culture of respect requires that the institution develop effective methods for responding to episodes of disrespectful behavior while also initiating the cultural changes needed to prevent such episodes from occurring. Both responding to and preventing disrespect are major

challenges for the organization's leader, who must create the preconditions for change, lead in establishing and enforcing policies, enable frontline worker engagement, and facilitate the creation of a safe learning environment.

When disrespectful behavior occurs, it must be addressed consistently and transparently. Central to an effective response is a code of conduct that establishes unequivocally the expectation that everyone is entitled to be treated with courtesy, honesty, respect, and dignity. The code must be enforced fairly

through a clear and explicit process and applied consistently regardless of rank or station.

Creating a culture of respect requires action on many fronts: modeling respectful conduct; educating students, physicians, and nonphysicians on appropriate behavior; conducting performance evaluations to identify those in need of help; providing counseling and training when needed; and supporting frontline changes that increase the sense of fairness, transparency, collaboration, and individual responsibility.

Previously,[1] we called attention to the pervasiveness of disrespect in health care and identified six types of disrespectful behavior that constitute threats to the safety and well-being of patients and health care workers. At one extreme of disrespectful behavior is disruptive conduct, which is rare, but unfortunately all too familiar to doctors and nurses in most hospitals. At the other extreme, lesser forms of disrespectful treatment are so common and so intimately woven into the health care environment and everyday work that they are accepted as normal and often are not recognized as disrespect, per se. This systemic disrespect is manifest in long work hours, high workloads, physical hazards, and psychological intimidation that affect doctors, nurses, and all health care workers, increasing the likelihood that they will make errors that harm

patients or themselves, and diminishing meaning and satisfaction in their daily work. For patients, systemic disrespectful treatment includes being made to wait for appointments, receiving patronizing and dismissive answers to questions, not being given full and honest disclosure when things go wrong, and not receiving the information they need to make informed decisions.

Although the origins of disrespectful behavior may reside in the personality characteristics of individuals and their responses to stressful environments, its expression is learned behavior, and it thrives in a culture that tolerates and supports disrespect. Eliminating disrespectful behavior in an organization thus requires transforming that organization's culture.

Cultural Transformation

Creating a culture of respect in health care is part of the larger challenge of creating a culture of safety. Studies of safe organizations reveal certain common cultural characteristics[2–4]: shared core values of transparency, accountability, and mutual respect. In these organizations, safety is an organizational priority shared by all. Safe organizations are "learning organizations"[5] that build

shared visions, use systems thinking, and respond to untoward events as opportunities for improvement rather than with denial and cover-up. They achieve high levels of mutual trust, collaboration, and accountability, both personal and institutional.

Respect is core to all of these behaviors. A culture of respect is a "precondition" for the changes needed to make health care safe. As noted, collaboration and teamwork are at the heart of successful implementation of safe practices. Without mutual respect and a sense of common purpose, people cannot and will not work effectively together.

Many of these characteristics are embodied in so-called "high-reliability organizations" (HROs), which have been proposed as a model for health care.[4,6,7] These are organizations that have succeeded in becoming extremely safe despite working in highly hazardous industries, such as aviation and nuclear power. Recently, Chassin and Loeb[8] reinforced earlier calls for health care organizations to adopt this model and identified three distinctive features of an HRO: "collective mindfulness," powerful tools to eliminate unsafe processes, and presence of a safety culture. Collective mindfulness is described by Weick et al[7]

as the condition in which everyone understands that even small failures can lead to catastrophic outcomes and accepts both individual and group responsibility for identifying hazards early and correcting them before harm occurs.

One of the leading students of HROs, Karlene Roberts, emphasizes that relational aspects of organizational cultures account for HROs' successes: interpersonal responsibility, person-centeredness, being supportive of coworkers, friendliness, openness in personal relations, creativity, credibility, interpersonal trust, and resiliency.[4,9] Respect is at the heart of these relationships.

We propose that creating a culture of respect is the essential first step in the journey to becoming a safe, high-reliability organization and will require transformation on several fronts. It should begin in medical school. Students need to learn about respect as a cornerstone of ethical professional behavior, and they should practice respect by working in teams with other professionals, such as nurses and pharmacists.[10] Both preclinical and clinical faculty must be held to standards of respectful treatment of students, trainees, and colleagues. Evidence of respectful behavior should be a job requirement for all leadership positions.

Because they are responsible for the continuum of undergraduate and graduate medical education, medical school deans have a vital interest in the learning environment in the hospitals and clinics where clinical medical education takes place. Therefore, ensuring safe and humane hospital working conditions and respectful treatment of students and residents by faculty are legitimate concerns of deans and their leadership teams.

However, the major responsibility for addressing these problems in the clinical environment belongs to the hospital chief executive officer (CEO). Creating a culture of respect requires that the institution develop effective means of responding to episodes of disrespectful behavior while simultaneously developing a supportive, mindful, and responsible culture that prevents such

episodes from occurring. Both are substantial challenges to leadership.

A Leadership Challenge

The responsibility for creating a culture of respect falls on the organization's leader because only he or she can set the tone and initiate the processes that will lead to change. We believe the CEO has five major tasks: (1) to motivate and inspire, (2) to establish preconditions for a culture of respect, (3) to lead the establishment of policies regarding disrespectful behavior, (4) to facilitate frontline worker engagement, and (5) to create a learning environment for residents and students.

Motivate and inspire

The initial task in changing culture is to create awareness of the problem to motivate others to take action, and to create a sense of urgency around doing so.[11] As behavioral theorists point out, a prerequisite for changing behavior is perceiving the need to change.[12] Our previous article[1] marshals arguments that can be used as a resource for that purpose. Even more powerful are local data, such as an institutional survey of nurses, residents, and others, which can reveal the extent of disrespectful treatment in a specific setting and which, in turn, can command immediate attention from all.

Next, the CEO must communicate the vision that mutual respect must become a core value for the institution and articulate his or her commitment to achieving it. All leaders, including department heads, division chiefs, and unit managers, will need to commit to this vision. A leader's commitment and enthusiasm are infectious, set the tone for the institution, and serve as powerful motivators. An end point of the process of motivating change might be reformulation of the institution's vision and mission statements.

Establish preconditions for a culture of respect

Staff are more likely to treat others with respect if they are treated with respect. Leaders must demonstrate concern for the safety and well-being of faculty and staff. Early on, the CEO should initiate a process of assessing and revising the policies and practices affecting work

hours and workloads for residents, physicians, nurses, and all workers. Attention should also be directed to mitigating physical hazards, such as needlesticks and back strain. Leaders' actions in these areas send a powerful message of respect that enhances employee morale and engagement.

During this phase, top leadership may engage in early discussions about how to implement former Alcoa CEO Paul O'Neill's preconditions for a culture of respect: enabling every worker to feel he or she is treated with respect, has the support he or she needs to do his or her job, and is appreciated.[13] Just putting these issues on the agenda sets the proper tone and demonstrates commitment to the stated vision.

Lead the establishment of policies regarding disrespectful behavior

In addition to articulating respect as a core value that supports the institutional mission, setting expectations for behavior is important in effecting change. This usually takes the form of a code of conduct, which should apply to all members of the community, not just professionals. Intrinsic to such a code is an individual's assumption of responsibility for his or her actions and interactions with others. Mutual respect, regardless of rank, station, or status, must be the explicit expectation. Because of the importance of a code of conduct in documenting expected behaviors, we provide recommendations for developing and implementing such a document in some detail below.

Facilitate engagement of frontline workers

Although a code of conduct and well-thought-out mechanisms for enforcement are essential first steps, creating a culture of respect requires much more. Organizational leaders need to address the systemic issues that cause and promote disrespectful behavior—a hierarchical system of control and a host of clinical and environmental stressors, among others. They need to prevent disrespectful behavior by eliminating its causes. We offer recommendations for approaching these issues below. The CEO's responsibility is to support these activities, remove barriers to achieving them, and maintain a sense of urgency and progress toward the stated mission.

Create a learning environment

Medical students too often suffer demeaning experiences at the hands of supervising faculty and residents. Because students and residents learn by emulating their teachers, disrespectful behavior of the faculty not only creates but also perpetuates a hostile environment. This must change. Both the CEO of the teaching hospital and the dean of the medical school have a responsibility to motivate their department chairs and other leaders to

> create learning cultures that emphasize patient safety, model professionalism, enhance collaborative behavior, encourage transparency, and value the individual learner. They should work to eliminate hierarchical authority gradients that intimidate others, emphasize that professionalism means, among other things, demonstrating mutual respect and non-tolerance for abusive or demeaning behaviors … (they) should declare and enforce a zero tolerance policy for confirmed egregious disrespectful or abusive behaviors…. Every teacher must be the kind of physician we want our students to become.[10]

Because many clinical faculty have not been trained in or exposed to these concepts, hospital and medical school leaders need to develop training programs for their faculty in basic safety skills: systems thinking, systems redesign, collaboration, and respectful conduct.

Responding to Disrespectful Behavior: Codes of Conduct

At its founding, in 1847, the American Medical Association (AMA) established a code of ethics, exhorting physicians, among other things "to be temperate in all things."[14] Subsequently, it has specifically recommended that medical staff by-laws include a code of conduct to address disruptive conduct.[15] The AMA defines disruptive conduct as "Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care."[16] The code-of-conduct recommendation includes details of an appropriate process for managing disruptive behavior.[15] In addition, the Joint Commission requires hospitals to have a process for managing disruptive behavior.[17] Since these recommendations and requirements have been issued, essentially all hospitals have developed codes of conduct.

Unfortunately, the quality of these codes and their enforcement vary considerably. Hospitals that are serious about creating a culture of respect must ensure that their codes are explicit and consistently enforced. A proper code reflects the organization's vision and values and is, therefore, a powerful statement of "who we are." The whole community must be involved in the development process: both those who will be affected by the code and those who will be responsible for its implementation. Successful codes are usually the product of an iterative and transparent process, championed by leaders throughout the organization.

Codes are not just about preventing disruptive conduct. The purpose of a code is to establish the expectations of the institution and its community in the whole realm of personal interactions. It is the standard against which behavior will be judged; therefore, the language must be clear and unambiguous. The core institutional value is that everyone is entitled to be treated with courtesy, honesty, respect, and dignity.

Some institutions have framed behavioral expectations as a compact, articulating what it is that each party—institution and participant—expects from the other.[18] These expectations include the responsibility of the institution to provide an environment that facilitates courtesy and respect.

Appropriate conduct should be defined explicitly—both in terms of expected behaviors (a credo) and unacceptable behaviors (boundaries). Defining activities that violate the institution's core values provides clarification and avoids ambiguity. When such clear guidelines are publicized widely, violators cannot hide under the cover of ignorance (e.g., "nobody told me"). An example of such guidelines is shown in List 1.[19]

List 1
Examples of Disruptive Behavior

Inappropriate words
- Profane, disrespectful, insulting, demeaning, or abusive language
- Shaming others for negative outcomes
- Demeaning comments or intimidation
- Inappropriate arguments with patients, family members, staff, or other care providers
- Rudeness
- Boundary violations with patients, family members, staff, or other care providers
- Gratuitous negative comments about another physician's care
- Passing severe judgment or censuring colleagues or staff in front of patients, visitors, or other staff
- Outbursts of anger
- Behavior that others would describe as bullying
- Insensitive comments about the patient's medical condition, appearance, situation
- Jokes or non-clinical comments about race, ethnicity, religion, sexual orientation, age, physical appearance, or socioeconomic or educational status

Inappropriate actions/inaction
- Throwing or breaking things
- Refusal to comply with known and generally accepted practice standards such that the refusal inhibits staff or other care providers from delivering quality care
- Use or threat of unwarranted physical force with patients, family members, staff, or other care providers
- Repeated failure to respond to calls or requests for information or persistent lateness in responding to calls for assistance when on-call or expected to be available
- Repeated and unjustified complaints about a colleague
- Not working collaboratively or cooperatively with others
- Creating rigid or inflexible barriers to requests for assistance/cooperation

Source: College of Physicians and Surgeons of Ontario, Ontario Hospital Association. Guidebook for Managing Disruptive Physician Behavior. Toronto, Ontario, Canada: College of Physicians and Surgeons of Ontario; 2008. Reprinted with permission.

In addition to a general code of conduct that applies to everyone, hospitals often find it advantageous to have specific codes for particular populations, such as physicians, nurses, and students. A professional code for physicians, for example, might specify in some detail unacceptable words and types of conduct—for example, profanity, demeaning comments or intimidation, boundary violations, outbursts of anger, bullying, throwing or breaking things, and using threats of physical force, as well as failing to respond to calls for help or refusal to follow required safe practices.

Once developed, the code should be disseminated widely through required educational programs to ensure universal understanding and support of the code's details. A key point is that every individual is responsible for his or her own respectful conduct and for confronting or reporting others who violate the code. Acceptance of the code—by written attestation—should be part of the hiring, credentialing, and recredentialing process for all professionals and employees.

Implementation

A code is only effective if it is supported at the highest levels of the institution,[20] which requires that leaders not only publicly endorse and enforce the code but also model recommended behaviors. A code of conduct from which some are exempt, or which leadership is unwilling to enforce, undermines the sense of shared responsibility. As long as the faculty member who brings in the most grant dollars, the surgeon with the largest volume, or the resident who is the relative of a senior faculty member is excused from responsibility for his or her actions, no statement of values or code of conduct will have credibility for the community at large or have much effect on conduct.

The best way to avoid these issues is to have a clear, explicit, well-understood mechanism for processing complaints and to respond consistently when violations occur. Fairness requires an official, transparent response that offers the accused the opportunity to explore the facts and the various elements that underlie the behavior. Such a process also opens up the possibility of exoneration, without which the innocent may be convicted by the rumor mill that exists in every organization.

The importance of a prompt, predictable, and appropriate response to an alleged violation cannot be overemphasized. The Ontario Guidebook includes the caution, "Intolerance of unprofessional behavior does not mean that punitive action is required. It does mean that some action is required."[19]

Guidelines for managing disruptive physician behavior have been published by various organizations. Guidelines from the AMA,[15] Vanderbilt University School of Medicine[20], and the College of Physicians and Surgeons of Ontario and the Ontario Hospital Association[19] are worthy of emulation. Box 1 shows common essential characteristics of effective policies that we have identified in these guidelines.

Reporting

As with all other safety reporting systems, to be successful, the process for reporting behavioral complaints must be safe, simple, and productive.[21] Reporting has to be easy for victims, who must be protected from personal or professional repercussions. The major barrier to reporting is the fear of retaliation. Therefore, the process and the safeguards must be widely known and respected; confidentiality is essential. Including an ombudsperson in the process may be useful.

The process for reporting should be specified in detail, including the items to be reported and to whom the report should be made. Reports should include the name of the reporter, the name of the person whose conduct is in question, the date and time of the incident, a description of the incident, and the names of any witnesses. If incidents are to be pursued and addressed and if disciplinary action is contemplated, providing anonymity to the reporter may not be possible, because the person being reported is entitled to know the details of any charge, and the person doing the investigation needs to be able to consult both sides.

How the institution responds to complaints is exceedingly important. Reporting systems work only if personnel perceive that complaints are taken seriously. The complainant should receive a report about follow-up action. More important, the hospital must

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Box 1
Characteristics of Effective Policies for Managing Disruptive Behavior

Fairness: The process for responding to breaches of the code of conduct must be perceived by all parties to be fair. Achieving fairness requires first that in the code development process all parties who will be affected are represented. Next, the process for responding to violations should be spelled out clearly and explicitly and disseminated to all. The policy should include a clear plan for progression of the review and disciplinary policy, if needed, as well as the consequences for failure to adhere. The document should include a clear statement that the policy applies to all, regardless of seniority or position. Notifying all to whom the code will apply that it has been adopted is important.

Consistency: The program of enforcement must be responsive to all complaints, large or small. Serious complaints must be investigated, and the subject must be informed of the complaint. Leadership commitment is required to overcome natural tendencies not to report or take action against a high-status individual or one whose departure, if necessary, would be damaging to the institution's reputation or income.

Graded response: The response to a complaint must be proportional to the nature of the incident. For a single, relatively minor infraction, an informal conversation initiated by a trusted peer may suffice. More egregious episodes or patterns of offensive conduct require a more formal approach. The policy must clearly define the process: Who is responsible for a contingency of actions for each level of staff? Under which circumstances and when is an investigation indicated? What are the criteria for advancing the response to a higher level?

Restorative process: The goal of the process should be to enable the individual to change his or her behavior and continue as a member of the health care community. Plans for remediation must be explicit, with clear markers, deadlines, and methods of monitoring. Disciplinary action should be reserved for those who are refractory to improvement or whose behavior is so outrageous as to constitute a threat to patient or worker safety. There are national programs to treat individuals who exhibit repeated disruptive behavior. Some of these are residential and are used by health institutions across the country.

Surveillance mechanisms: Without effective mechanisms for identifying individuals with problems, policies are meaningless. In addition to safe reporting of inappropriate behavior, surveillance should be proactive, such as the use of "360-degree" evaluations, to identify problems early.

publicize the response to the institutional community (while protecting privacy by referring to the case in the abstract without mentioning names). By making these actions known, the institution demonstrates its commitment and accountability and draws a clear line between acceptable behavior and behavior that is not tolerated.

The Guidebook for Managing Disruptive Physician Behavior of the College of Physicians and Surgeons of Ontario and the Ontario Hospital Association provides an example of a complaints procedure.[19] (Appendix C)

Prevention of disrespect

Although having effective policies and procedures to deal with disruptive behavior is essential, the goal is to prevent such conduct. In its behavioral guidelines, the Joint Commission suggests that hospitals not just develop and implement codes of conduct but also take other actions to reduce intimidating behavior.[17] These include educating physicians and nonphysicians on appropriate professional behavior and holding everyone accountable for modeling desirable behaviors. In an HRO, every individual feels personally accountable for his or her own and colleagues' behavior, collaborates to anticipate and prevent errors, and commits to not tolerate disrespectful conduct.

Performance evaluations. A principle of medical professionalism is that physicians take responsibility for their peers.[22] However, in practice, physicians rarely do so spontaneously. Instead of relying on peers or complaints to identify those in need of help, routine evaluation for professional behavior as part of an annual, formal process (e.g., "360-degree" evaluations) can effectively identify individuals who exhibit disrespectful behavior. Evaluating everyone—not just suspected "bad apples"—ensures fairness and frames the evaluation as a tool for quality improvement rather than discipline. Appropriately performed, these "early warning" systems can provide valuable information about interaction and communication problems, enabling leaders to address them before they escalate to disruptive or disagreeable conduct that requires disciplinary action.

Behaviors that may be uncovered are listed in the Ontario Guidebook.[19] Examples include failing to be on time for meetings and attend to duties, inappropriate dress or conduct, failure to show respect for coworkers or patients, blaming others for work or personal problems, and emotional reference to personal upset over recent events in the workplace or personal life.

Culture change. The work of prevention requires much more than early detection of problems—It requires a change in the institution's culture, which requires numerous individual changes made in daily routines by frontline workers. These workers need support and encouragement. The challenges are formidable: creating transparency, breaking down authoritarianism while maintaining accountability, learning to work in teams, creating an environment in which change is safe, cultivating a "just culture" in which individuals are not punished for making errors but are held accountable for following safe practices,[23] and making respect the core of everyone's identity ("who we are").

Changes of this magnitude in our complex health care systems require receptivity to a wide range of approaches. Most powerful are interventions that build on inherent strengths, such as appreciative inquiry (AI), which is based on the understanding that "organizations are socially constructed and generate the contexts in which people act and interact to create new realities through learning and innovation."[24] Interaction among clinicians is critical to how they respond to new policies and to how they are adopted. Instead of fixating on what is wrong and how to fix it—which stimulates fear, shame, defensiveness, and false expectations—AI focuses on what is right, what is working, and how to have more of it. Thus, expectations and behavior organize around a core perception of capability and hopefulness rather than deficit.[25] AI has also been used successfully for teaching professionalism to medical students.[25,26]

The pairing of positive and negative approaches is crucial. An official response to disruptive behavior affirms the commitment of the organization to respect, transparency, and fairness. An organization that offers no official

and transparent response to disruptive behavior quickly loses its moral authority, degrading any opportunity for emphasizing strengths and positive features to bring about culture change.

Cultivating a Culture of Respect

Disrespectful behavior is at the core of the dysfunctional culture prevalent in health care systems. It is a "root cause" of the difficulties encountered in developing team-based approaches to improving patient safety and implementing safe practices. The most extreme forms of disrespect—disruptive and humiliating behaviors—induce errors. Disrespect underlies the tensions and dissatisfactions that diminish joy and fulfillment in work for many types of health care workers. Being treated disrespectfully is devastating for patients. The time has come for health care organizations to do something about this invidious problem and cultivate a culture of respect.

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A Multi-institutional Study Exploring the Impact of Positive Mental Health on Medical Students' Professionalism in an Era of High Burnout

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Abstract

Purpose

Although burnout is associated with erosion of professionalism and serious personal consequences, whether positive mental health can enhance professionalism and how it shapes personal experience remain poorly understood. The study simultaneously explores the relationship between positive mental health and burnout with professionalism and personal experience.

Method

The authors surveyed 4,400 medical students at seven U.S. medical schools in 2009 to assess mental health (categorized as languishing, moderate, and flourishing) and burnout. Additional items explored professional behaviors, beliefs, suicidal ideation, and serious thoughts of dropping out.

Results

A total of 2,682/4,400 (61%) responded. Prevalence of suicidal ideation (55/114 [48.2%], 281/1,128 [24.9%], and 127/1,409 [9.1%]) and serious thoughts of dropping out (15/114 [13.2%], 30/1,128 [2.7%], and 14/1,409 [1.0%]) decreased as mental health improved from languishing, moderate, and flourishing, respectively (all $P < .0001$); this relationship between personal experience and mental health persisted independent of burnout (all $P < .001$). As mental health improved, the prevalence of unprofessional behaviors (i.e., cheating and dishonest behaviors) also declined, whereas students' altruistic beliefs regarding physicians' responsibility toward society improved. For example, 33/113 (29.2%), 426/1,120 (38.0%), and 718/1,391 (51.6%) of students with languishing, moderate, and flourishing mental health endorsed all five altruistic professional beliefs ($P < .0001$). The relationship between professional beliefs and mental health persisted among students with burnout, whereas fewer relationships were found among students without burnout.

Conclusions

Findings suggest that positive mental health attenuates some adverse consequences of burnout. Medical student wellness programs should aspire to prevent burnout and promote mental health.

Professional burnout and other forms of psychological distress are common among physicians and medical students.[1–4] This distress has serious personal consequences and may compromise patient care,[4–7] the size of the physician workforce,[8,9] competency,[10] and professionalism.[11] Despite these adverse consequences, whether or not a state of *positive* mental health enhances professionalism is unknown. Insight in this area may be helpful to wellness programs for physicians and medical students in helping such programs decide whether their primary aim should be to eliminate burnout, to pursue the more elusive goal of promoting positive mental health, or to do both.

The World Health Organization suggests that "health is a complete state of physical, mental, and social well-being and not merely the absence of disease or infirmity."[12] Similarly, the 1999 report of the surgeon general on mental health considered mental health (1) distinct from the absence of mental illness, (2) indispensable to personal well-being, relationships, and contributions to society, and (3) in need of immediate attention.[13] Although what it means to be mentally healthy varies between cultures and is influenced by personal values,[13] it is commonly viewed as having positive feelings (e.g., happiness, positive feelings toward one's life) and positive functioning in life (e.g., sense of purpose, fulfilling relationships, sense of belonging, contributing to society) rather than simply the absence of negative feelings, symptoms, or impairment (e.g., the absence of professional burnout does not mean that a person is mentally healthy or thriving).[12–15] Conceptually, framing positive mental health around the combination of feelings and function is similar to (but in the opposite direction as) the definitions of mental illness used in the *Diagnostic and Statistical Manual of Mental Disorders*[16] (e.g., a diagnosis of depression requires both feelings of depressed mood/anhedonia as well as malfunctioning). Common to both positive and negative mental health conditions is a reliance on the individuals' perceptions and self-assessment.

Despite calls for research on the promotion of positive mental health since the 1950s,[13,17] there remains a paucity of research in this area, and the beneficial effects of achieving high mental health remain poorly understood.[18] We performed a multicenter study of medical students to explore the relationship between positive mental health and burnout with professionalism and personal experience.

Method

Participants and procedures

We have described the methods of data collection for this large, multisite study in detail elsewhere.[11] Briefly, all 4,400 medical students from seven U.S. medical schools (chosen because of their diverse student population, variation in size, geographic location, public/private status, and the presence of a local investigator willing to complete the site-specific tasks necessary for student participation) were eligible to participate after the institutional review board at each school approved the study. In 2009, the survey research center at Mayo Clinic invited these students to participate in the study. Participation was elective, and responses were anonymous.

Study measures

For a summary of the various study measures discussed below, see Appendix 1.

Mental health. The survey included the Mental Health Continuum Short Form (MHC-SF) to measure mental health.[19] The MHC-SF is a 14-item instrument assessing emotional (three items), psychological (one from each of the six dimensions of Ryff's construct of psychological well-being),[20] and social well-being (one from each of the five dimensions of Keyes'[21] model of social well-being).

The MHC-SF items measure the frequency with which responders have experienced symptoms of positive mental health during the past month (never, once or twice, about once a week, two or three times a week, almost every day, every day). Responders receive an overall summary score as well as subscores within each domain (emotional, psychological, and social well-being). The average MHC-SF score for the general U.S. population is 47.68 (SD 12.28).[22] On the basis of established MHC-SF criteria,[19] respondents are considered to have *flourishing* mental health if they have experienced ≥1 of the 3 symptoms of emotional well-being (i.e., they were happy, interested in life, satisfied) and ≥6 of the 11 symptoms of either positive social functioning (e.g., they felt they had something important to contribute to society, that they belonged to a community) or of positive psychological functioning (e.g., they felt confident to express their own opinions, that life has meaning to it, were positive about

themselves) either daily or almost every day during the past month. Respondents who indicate a low frequency (i.e., "never" or "once or twice" during the past month) on ≥1 emotional well-being items and a low frequency on ≥6 signs of positive functioning have *languishing* mental health. Respondents who are neither flourishing nor languishing are considered to have *moderate* mental health. Previous population-based studies have borne out that flourishing mental health is better than moderate mental health and that moderate mental health is better than languishing mental health, as evidenced by work effort, conduct, absenteeism, and health care utilization.[15,23,24]

Burnout. The survey included the Maslach Burnout Inventory (MBI)[25] to measure burnout. The MBI, widely considered the criterion standard,[3] measures three domains of burnout: emotional exhaustion (EE), depersonalization (DP), and low sense of personal accomplishment (PA). The three-factor structure of the MBI has been confirmed in medical students.[26] The reliability of the MBI in medical students is supported by Cronbach coefficient alphas for the EE, DP, and PA domains of 0.89, 0.78, and 0.81, respectively, which are nearly identical to the respective performances of the MBI in these domains in large population samples.[18] Predictive validity evidence is supported by studies showing relationships between burnout, as measured by the MBI, and suicidal ideation,[27] serious thoughts of dropping out,[9] and low empathy[28] among medical students. According to commonly accepted convention, we used EE, DP, and PA scores both as continuous variables and also as high scores using established cutoffs.[25] Because high scores on either the EE (≥27) or DP (≥10) scales can distinguish clinically burned-out individuals from non-burned-out ones,[29] burnout (as a dichotomous variable) was defined as having high EE and/or high DP.[30,31]

Personal experiences. To build on earlier work showing relationships between burnout and both suicidal ideation and serious thoughts of dropping out of medical school,[9,27] the survey also included items about suicidal ideation and serious thoughts of dropping out of medical school within the previous 12 months.

Professional behaviors and beliefs. Previously published questionnaire items

were used to assess professional behaviors and beliefs.[11] Items regarding professional conduct explored cheating and dishonest professional behaviors that had been reported in previous studies of medical students.[32–35] Altruistic professional beliefs were assessed by asking students to rate their levels of agreement with statements regarding physicians' responsibility to society derived from the Medical Students' Attitudes toward Providing Care for the Underserved (MSATU) instrument.[34,35] Consistent with previous reports,[11] responses to these items were dichotomized to "agree" (responses of "strongly agree" or "agree") or "neutral/disagree" (responses of "neutral," "disagree," or "strongly disagree") for analysis. Last, students were asked if they had provided care to the medically underserved in a community setting that was not related to a clerkship or required activity, to explore whether they had pursued such activities of their own initiative.

Statistical analysis

Standard descriptive summary statistics were used to characterize the sample. Differences in a dependent outcome variable by independent variables were evaluated using the Kruskal–Wallis test (continuous variables) or chi-square test (categorical variables), as appropriate. All tests were two-sided with type I error rates of 0.05. Participants were excluded from individual analyses if their data involved in the comparison were missing. The large sample size provided high precision. With 2,682 observations, percentages are accurate to within 2 percentage points with 95% confidence. Mean values are accurate to within 4% of the SD of the variable involved, a very small effect size. All analyses were conducted using Linux SAS 9.2 (Cary, North Carolina).

Results

Of 4,400 medical students surveyed, 2,682 students returned surveys (response rate of 61%). Compared with the overall sample, responders were slightly more likely to be female (48.6% versus 45.1%), younger than 25 (32.6% versus 25.9%), and white (78.4% versus 68.4%). (We previously reported the demographic characteristics and MBI scores of the same group of medical students.)[11] Collectively, 42.1% (1,079/2,562) had high EE, 35.8% (860/2,404) had high DP, and 52.5% (1,398/2,661) had positive

Table 1

Associations Between Mental Health and Demographic Characteristics Among Students at Seven U.S. Medical Schools, 2009*

Variable	Languishing mental health,[†] no. (%)	Moderate mental health,[†] no. (%)	Flourishing mental health,[†] no. (%)	Overall *P* value for variable
Gender				.6084
Male	55 (4.1)	556 (41.7)	721 (54.1)	
Female	56 (4.4)	555 (43.4)	667 (52.2)	
Missing	3 (0.0)	17 (0.0)	21 (0.0)	
Age				.0947
<25 years	29 (3.4)	382 (44.8)	441 (51.8)	
25–30 years	65 (4.4)	611 (41.2)	807 (54.4)	
>30 years	19 (6.6)	125 (43.1)	146 (50.3)	
Missing	1 (0.0)	10 (0.0)	15 (0.0)	
Relationship status				<.0001
Single/divorced	78 (4.9)	727 (45.6)	790 (49.5)	
Married/partner	33 (3.2)	394 (37.9)	613 (58.9)	
Missing	3 (0.0)	7 (0.0)	6 (0.0)	
Have children				.0517
Yes	8 (2.6)	115 (38.1)	179 (59.3)	
No	104 (4.4)	1,007 (43.1)	1,227 (52.5)	
Year in school				<.0001
First	16 (2.3)	298 (43.3)	374 (54.4)	
Second	45 (6.8)	315 (47.6)	302 (45.6)	
Third	31 (5.1)	264 (43.6)	311 (51.3)	
Fourth	15 (2.6)	206 (35.9)	353 (61.5)	
Other[‡]	7 (6.2)	42 (37.2)	64 (56.6)	
Missing	0 (0.0)	3 (0.0)	5 (0.0)	
Debt				.4550
<$49,999	53 (3.8)	608 (43.6)	733 (52.6)	
$50,000–99,999	31 (5.2)	252 (42.1)	315 (52.7)	
>$100,000	30 (4.6)	261 (40.3)	356 (55)	
Missing	0 (0.0)	7 (0.0)	5 (0.0)	
Ethnicity: Hispanic/Latino				.1952
Yes	8 (5.8)	67 (48.2)	64 (46)	
Not	105 (4.3)	1,035 (42.1)	1,320 (53.7)	
Missing	1 (0.0)	26 (0.0)	25 (0.0)	
Race				.0003
White	81 (3.9)	856 (41)	1,151 (55.1)	
Not white	32 (6.2)	249 (48)	238 (45.9)	
Missing	1 (0.0)	23 (0.0)	20 (0.0)	

*The table shows that relationship status, parental status, year in medical school, and race were significantly associated with student's degree of mental health; however, no associations were observed based on sex, age, debt, or ethnicity.

[†] Of the 2,682 students who returned surveys, all but 31 could be assigned a category of mental health (i.e., languishing, moderate, or flourishing) based on responses to the Mental Health Continuum Short Form (see the Method section).

[‡] Students who took a break from medical school to pursue enrichment activities, such as research projects or graduate work.

depression screens. In addition, 17.4% (465/2,670) of respondents reported suicidal ideation, and 11.3% (297/2,627) reported serious thoughts of dropping out of medical school in the previous 12 months.

Our data confirmed the three-factor structure of the MHC-SF. Cronbach alpha was 0.921 for the entire MCH-SF and 0.899, 0.802, and 0.875 for the three domains of emotional, psychological, and social well-being, respectively, which is

similar to the performance of the MCH-SF in other samples.[36,37]

Students' mean MHC-SF score was 47.0 (SD 12.67). Of the 2,682 students who returned surveys, all but 31 could
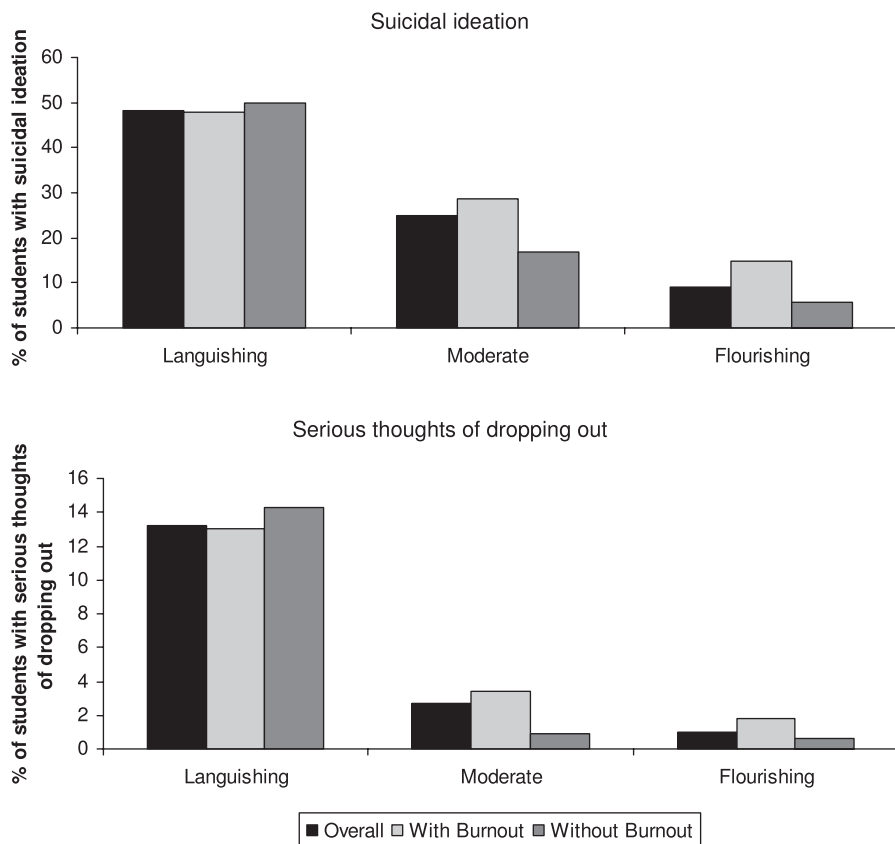
Figure 1 Relationship between suicidal ideation and serious thoughts of dropping out with degree of mental health (i.e., languishing, moderate, and flourishing) and professional burnout. The prevalence of suicidal ideation (top panel) and serious thoughts of dropping out of medical school (bottom panel) decrease as mental health status improves (all *P* < .001) regardless of whether or not individuals had professional burnout. The higher rate of suicidal ideation and serious thoughts of dropping out in the moderate and flourishing individuals who are burned out is significantly higher than in those who are not burned out (all *P* < .0001). The figure reflects data from the responses of 2,682 medical students from seven medical schools who were surveyed in 2009 to assess their mental health and whether they were burned out.

be assigned a category of mental health (i.e., languishing, moderate, or flourishing) based on responses to the MHC-SF. Overall, 1,409 (53.1%) students were flourishing, 1,128 (42.5%) were moderately mentally healthy, and 114 (4.3%) were languishing. The prevalence of students with flourishing, moderate, and languishing mental health by demographic characteristics is shown in Table 1. Relationship status, parental status, year in medical school, and race were significantly associated with student's degree of mental health; however, no associations were observed based on sex, age, debt, or ethnicity.

Relationship of positive mental health with personal experiences

Flourishing students had a lower prevalence of suicidal ideation within the last 12 months (127/1,406 [9.0%])

than did those who were moderately mentally healthy (281/1,119 [25.1%]) or languishing (55/114 [48.2%]; overall *P* < .0001). Similarly, flourishing students were less likely to report serious thoughts of dropping out of medical school (14/1409 [1.0%]) than were those who were moderately mentally healthy (30/1,128 [2.7%]) or languishing (15/114 [13.2%]; overall *P* < .0001).

On the basis of previous work showing a strong association between professional burnout and recent suicidal ideation[27] and serious thoughts of dropping out of medical school,[9] we repeated the analysis by burnout status. As shown in Figure 1, positive mental health stratified students' risk of suicidal ideation and serious thoughts of dropping out even after students with burnout were excluded (both *P* < .0001).

Relationship of positive mental health with professional behavior

Students who were languishing were more likely to have engaged in unprofessional behaviors (i.e., cheating and dishonest behaviors). The mean numbers of unprofessional behaviors were 0.4 (SD, 0.62), 0.4 (SD, 0.71), and 0.5 (SD, 0.85) for flourishing, moderate, and languishing mental health, respectively; overall *P* = .01. When each professional conduct item was evaluated separately, the prevalence of six out of seven cheating and dishonest behaviors decreased as students' mental health improved (see Table 2).

Given the previously reported relationship between burnout and professional conduct,[11] we repeated the just-described analysis by burnout status. There was no difference in the mean number of unprofessional behaviors among those with languishing, moderate, or flourishing mental health after burnout status was taken into account. With respect to individual behaviors, among students with burnout, mental health status did not relate to professional conduct except for one of the seven behaviors (i.e., signed an attendance sheet for a friend who was not present: 50/482 [10.4%], 95/706 [13.5%], and 18/90 [20.0%] for flourishing, moderate, and languishing mental health, respectively, overall *P* = .03). Similarly, in students without burnout, mental health status did not relate to professional conduct except for one other behavior (i.e., taking credit for another person's work: 1/850 [0.1%], 1/328 [0.3%], and 1/13 [7.7%] for flourishing, moderate, and languishing mental health, respectively, overall *P* < .0001).

Relationship of positive mental health with professional beliefs

In aggregate, students who were flourishing endorsed a larger number of the five altruistic professional beliefs regarding physicians' responsibility to society (3.3 [SD 1.57], 3.7 [SD 1.40], and 4.0 [SD 1.32] for languishing, moderate, and flourishing mental health; overall *P* < .0001). The prevalence of each professional belief also increased as students' mental health improved (see Figure 2). For example, students with flourishing mental health had twofold-higher odds of endorsing the belief that they could personally make an impact on the problem of the medically underserved

Table 2

Relationships Between Professional Behaviors and Mental Health Among Students at Seven U.S. Medical Schools, 2009*

Cheating and dishonest clinical behaviors	Languishing mental health, no. (%)[†]	Moderate mental health, no. (%)[†]	Flourishing mental health, no. (%)[†]	P value
Signed an attendance sheet for a friend who was not present	18 (15.9)	118 (10.6)	104 (7.5)	.0070
Copied from a crib sheet or another student during a closed-book exam	1 (0.9)	21 (1.9)	19 (1.4)	.8020
Permitted another student to copy from you during a closed-book exam	0 (0)	11 (1)	3 (0.2)	.0224
Took credit for another person's work (e.g., papers, projects, clinical work, or research)	3 (2.7)	8 (0.7)	4 (0.3)	.0122
Reported a lab test or X-ray as pending when not sure it was ordered or knew it had not been[‡]	8 (7.1)	39 (3.5)	44 (3.2)	.0011
Reported result as normal when you knew it had been inadvertently omitted from the physical exam[‡]	30 (26.8)	289 (26)	323 (23.3)	.0086
Said you ordered a test when you actually had not[‡]	2 (1.8)	8 (0.7)	6 (0.4)	.0082
Endorsed one or more unprofessional behaviors	34 (53.1)	285 (47.5)	336 (40.1)	.0063

* The table shows a relationship between 6 out of 7 cheating and dishonest behaviors and students' mental health.
† Of the 2,682 students who returned surveys, all but 31 could be assigned a mental health category (i.e., languishing, moderate, and flourishing) based on responses to the Mental Health Continuum Short Form (see the Method section). Percentages exclude missing values.
‡ Responses pertaining to these clinical behaviors only analyzed for third- and fourth-year students.

than did students with moderate mental health (OR 2.113; 95% CI 1.424, 3.136). In turn, students who were moderately mentally healthy had 80% higher odds of having such a belief than did students who were languishing (OR 1.811; 95% CI 1.553, 2.139). Overall, 33/107 (30.8%), 426/1,077 (39.6), and 718/1,359 (52.8%) of students with languishing, moderate, and flourishing mental health

endorsed all five altruistic professional beliefs ($P < .0001$). Student mental health also correlated with whether or not students had actually provided care to the medically underserved outside of a clerkship or required activity (53/113 [46.9%], 615/1,113 [55.3%], and 802/1,378 [58.2%] for languishing, moderate, and flourishing mental health, overall $P = .04$).

Given the previously reported relationship between burnout and students' altruistic professional beliefs about physicians' responsibility to society,[14] we repeated this analysis by burnout status (see Figure 3). The relationship between professional beliefs and mental health persisted among students with professional burnout in that the mean number of favorable beliefs toward serving the underserved was lowest for those who were languishing (3.2, SD 1.52), higher for those who were moderately mentally healthy (3.6, SD 1.42), and highest for those who were flourishing (4.0, SD 1.36, overall $P < .0001$). For students with professional burnout, a statistically significant association with mental health was observed for three of the five items regarding physicians' responsibility to society (see Figure 3, top panel). Similarly, students with burnout who were flourishing* were more likely to:

I personally want to be involved in providing care for the medically underserved during my medical career.

I feel I am personally able to make an impact on the problem of meeting the needs of the medically underserved.

Medical care should be provided without charge or very limited charge for those who cannot pay.

Medical students should be concerned about the problems facing the medically underserved.

Everyone is entitled to receive adequate medical care regardless of ability to pay.
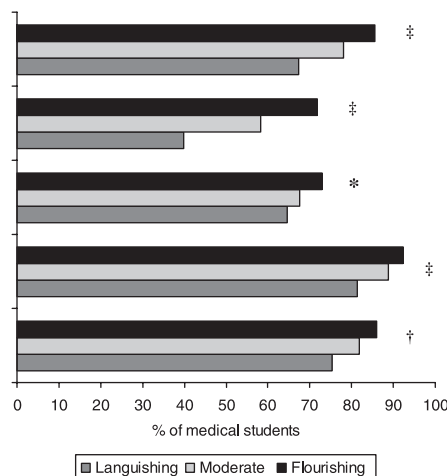
Figure 2 Associations between degrees of mental health (i.e., languishing, moderate, and flourishing) and self-reported altruistic professional beliefs among 1,345 U.S. medical students. The prevalence of endorsing altruistic professional beliefs decreased in a stepwise fashion as mental health worsened. The 1,345 medical students were from seven medical schools and were among the 2,682 students who responded in 2009 to a survey to assess students' mental health and whether they were burned out.
*$P < .01$, †$P < .001$, ‡$P < .0001$.

* We speculate that students who are flourishing yet burned out may feel that their medical training is of great purpose and that they have a sense they are contributing to society in a meaningful way but are simultaneously exhausted and desensitized. Thus they believe in their work, are committed to it, but have lost some of their ability to engage in it because of personal depletion. Nonetheless, we believe that only an identified survey with qualitative data can define the profile of such a student.

- endorse a desire to provide care for the medically underserved (61/92 [66.3%], 569/739 [77.0%], and 426/501 [85.0%] for languishing, moderate, and flourishing mental health, respectively, overall $P < .0001$);

- feel they could make an impact on meeting the needs of the medically underserved (32/92 [34.8%], 402/740 [54.3%], and 353/500 [70.6%] for languishing, moderate, and flourishing mental health, respectively, overall $P < .0001$); and

- believe that medical students should be concerned about meeting the problems facing the underserved (73/92 [79.3%], 644/738 [87.3%], and 454/499 [91.0%] for languishing, moderate, and flourishing mental health, respectively, overall $P = .004$).

These findings suggest that, among those with burnout, positive mental health may reduce some negative consequences of burnout, especially with regard to certain aspects of professionalism.

Although there was a relationship between altruistic professional beliefs and mental health among students with professional burnout, the difference in the mean number of altruistic professional beliefs endorsed by students without burnout who were languishing, moderately mentally healthy, or flourishing was not statistically significant. As shown in Figure 3, bottom panel, when analyzing the individual altruistic professional beliefs among students free of burnout, the relationship with mental health was statistically significant for only one of five items (i.e., everyone is entitled to receive adequate medical care regardless of ability to pay: 10/14 [71.4%], 268/327 [82.0%], and 741/852 [87.0%] for languishing, moderate, and flourishing mental health, respectively, overall $P = .03$).

Discussion

Data from this large, multi-institutional study suggest that higher mental health correlates with medical student professionalism and a better personal experience. Students' mental health stratified the likelihood that students reported engaging in cheating/dishonest clinical behaviors as well as their altruistic views regarding physicians' responsibility to society. Students' degree of mental health also stratified whether students had experienced recent suicidal ideation or considered dropping out of medical school.

Although the association between suicidal ideation and serious thoughts of dropping out with positive mental health persisted independent of burnout, a more complex relationship seems to exist between positive mental health and professional behaviors and students' altruistic views regarding physicians' responsibility to society. Although positive mental health had a more limited relationship to professional behaviors and altruistic views about physicians' responsibility to society among students without professional burnout, for students with burnout, positive mental health seemed to have a substantial effect on whether they maintained altruistic professional values. This study builds on a previous analysis showing a relationship between burnout and altruistic professional beliefs[11] by documenting an incremental preservation of altruistic views about physicians' responsibility to society as positive mental health improves. In sum, these findings suggest that efforts to eliminate suicide attempts and attrition among medical students and to foster altruistic professional values should focus not only on preventing

Students with burnout

I personally want to be involved in providing care for the medically underserved during my medical career.

I feel I am personally able to make an impact on the problem of meeting the needs of the medically underserved.

Medical care should be provided without charge or very limited charge for those who cannot pay.

Medical students should be concerned about the problems facing the medically underserved.

Everyone is entitled to receive adequate medical care regardless of ability to pay.

% of medical students

Students without burnout

I personally want to be involved in providing care for the medically underserved during my medical career.

I feel I am personally able to make an impact on the problem of meeting the needs of the medically underserved.

Medical care should be provided without charge or very limited charge for those who cannot pay.

Medical students should be concerned about the problems facing the medically underserved.

Everyone is entitled to receive adequate medical care regardless of ability to pay.

% of medical students

☐ Languishing ☐ Moderate ■ Flourishing

Figure 3 Associations between degrees of mental health (i.e., languishing, moderate, and flourishing) and self-reported altruistic professional beliefs among 1,345 U.S. medical students for students with and without burnout. The prevalence of endorsing most altruistic professional beliefs decreased in a stepwise fashion as mental health worsened among students with burnout (top panel) and without burnout (bottom panel), with a difference in prevalence reaching statistical significance more often among those with burnout. The 1,345 medical students were from seven medical schools and were among the 2,682 students who responded in 2009 to a survey to assess students' mental health and whether they were burned out.
*$P < .01$, †$P < .0001$, ‡$P < .03$.

burnout but also on optimizing personal mental heath.

Although limited existing data suggested that lower stress and fatigue[36] and mindfulness[37] may reduce the risk of burnout, little is known about approaches to promote positive mental health that could be incorporated into medical student wellness programs required by the Liaison Committee on Medical Education.[38] Further study is warranted on the usefulness of strategies with the potential to bolster positive mental health, such as structured opportunities for students to contribute to a community, build meaningful relationships, and reflect on their well-being, autonomy, personal growth, personal value, and self-acceptance.[19,20] Conceptually common to initiatives intended to prevent burnout and promote positive mental health is the recognition of self-care as a core competency for physicians, as also advocated by the Royal College of Physicians and Surgeons of Canada (in CanMEDS 2005)[39] and the General Medical Council of the United Kingdom (in The New Doctor 2009).[40] Formalization of self-care as a core competency within the United States (e.g., by the Accreditation Council for Graduate Medical Education and the Physician Charter) could further stimulate curricula innovation and evaluation to advance evidence-based approaches to equip trainees and physicians with skills that promote mental health and resilience. Meanwhile, given the high prevalence of students' distress, schools should take steps to measure their students' mental health while they develop methods to help improve it.

This study is limited by several factors. First, we relied on self-reported mental health status that was not corroborated by formal clinical assessment. Second, positive mental health is a multifaceted and evolving construct, and it is unlikely that the MHC-SF measures all the components that contribute to mental health. Third, because this study was cross-sectional, the causality and the direction of the relationships cannot be determined. Fourth, although our sample size was large and our response rate of 61% is robust for multi-institution physician[41] and medical student surveys,[1]

our findings may be vulnerable to response bias. Our sample size, however, provides estimates of the mental health continuum diagnosis within 1.9% of the actual population value with 95% confidence. Fifth, the items regarding physicians' responsibility toward society are vulnerable to social desirability bias. However, given the Web-based, anonymous nature of this study, such bias is unlikely to have been substantial. Last, we recognize that other factors, such as personal experiences, family income, and political viewpoints, not explored in this study, may also influence students' attitudes toward the underserved.

The study has several important strengths. First, it is a large, multi-institutional study of students attending diverse public and private medical schools. Second, responders were representative of U.S. medical students with respect to sex, relationship status, and parental status. Third, we used established instruments to measure burnout and mental health. Fourth, items assessing professional behaviors and beliefs were derived from the literature[32–35] and the MSATU.[42,43]

Conclusions

Our data show that positive mental health seems to be associated with enhanced professional behaviors and beliefs among U.S. medical students. For the good of both society and individual students, medical schools should help students not only avoid professional burnout but also learn strategies that promote positive personal mental health. Future studies are needed to evaluate the impact of positive mental health on professional development and evaluate the efficacy of interventions designed to promote positive mental health.

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Appendix 1

Categories and Dimensions Assessed to Explore the Relationship Between Positive Mental Health and Burnout With Professionalism and Personal Experience*

Mental health categories[†]	Burnout categories	Professionalism dimensions	Personal dimensions
• Languishing • Moderate • Flourishing	• High • Low	• Behaviors (e.g., cheating) • Professional beliefs (e.g., altruism)	• Suicidal ideation • Serious thoughts of dropping out of medical school

*The authors studied 1,345 medical students from seven U.S. medical schools in 2009. These students completed the Mental Health Continuum Short Form and Maslach Burnout Inventory to measure positive mental health and symptoms of burnout. Additional question items inquired about cheating and dishonest professional behaviors, attitudes regarding physicians' responsibility to society (derived from the Medical Students' Attitudes toward Providing Care for the Underserved instrument), suicidal ideation within the previous 12 months, and serious thoughts of dropping out of medical school within the previous 12 months.

† *Languishing*—low frequency (never or less than three times a month) of experiencing emotional well-being (e.g., happiness, satisfaction) and signs of positive social (e.g., sense of belonging or contributing to society) or psychological (e.g., sense of confidence, positive self-worth) functioning. *Moderate mental health*—those who are neither languishing or flourishing. *Flourishing*—high frequency (daily or nearly every day during the past month) of experiencing emotional well-being and signs of positive social or psychological functioning.

Creating a Longitudinal Environment of Awareness: Teaching Professionalism Outside the Anatomy Laboratory

Trahern W. Jones

Abstract

Anatomy educators have long understood the role that professionalism education plays in the dissection laboratory. The process of dissecting human material forces students to address such issues as human mortality, their responsibility to the vulnerability of the deceased, their privileged position in society, and their commitment to scientific ideals. Educators have offered a wealth of opinions and curricula dedicated to teaching professionalism in first-year anatomy courses. That they have risen to this challenge is laudable. However, professionalism education is a longitudinal process of acculturation. What happens, then, to students after they leave the anatomy classroom? As it is not taught in other basic science courses, professionalism education effectively becomes a null curriculum, teaching students to compartmentalize professionalism questions so that they can be addressed in anatomy courses or during dedicated professionalism course work. In their training, medical students spend 4 to 12 years navigating this shifting environment of hidden, null, or explicit curricula, which have a significant impact on their attitudes and character.

In this perspective, the author highlights, from his experience as a medical student, specific professionalism challenges in anatomy—such as encountering mortality, enacting contracts with society and those who are most vulnerable, and upholding scientific excellence—and discusses how these challenges are addressed by anatomy educators. He then provides analogous examples of opportunities to teach professionalism in other basic science courses, such as pathology, microbiology, and pharmacology. He concludes by describing the goal of incorporating professionalism into all basic science courses—a longitudinal, cohesive environment of awareness.

Anatomy educators have long understood the role that professionalism education plays in the dissection laboratory.[1] The process of dissecting human material forces students to address such issues as human mortality, their responsibility to the vulnerability of the deceased, their privileged position in society, and their commitment to scientific ideals, among other issues. Education leaders have offered a wealth of opinions and curricula dedicated specifically to teaching professionalism in first-year anatomy courses, such as those described in the July 2006 professionalism-centered issue of the journal *Clinical Anatomy*.[2] Many view a medical student's first human dissection as a sentinel moment in his or her career—without proper guidance, students may respond with solutions to these issues that are antithetical to medical professionalism.[3,4]

Students may perceive the above-mentioned professionalism challenges in anatomy as problems without easy solutions.[5] The literature on medical professionalism suggests that students must develop an approach to addressing these ill-structured or ambiguous challenges.[5] The very presentation of such challenges, then, offers a training ground for burgeoning health professionals, as they weigh the consequences of any proposed solutions. Many anatomy educators now seek to explicate such challenges with students to cultivate what could be called an "environment of awareness." When students confront professionalism problems overtly, professionalism becomes an "as-lived" experience for them, relevant to learning anatomy and to the practice of medicine in general.[6]

That anatomy educators have risen to the challenge of teaching professionalism is laudable. However, professionalism education is a longitudinal process of acculturation; thus, one wonders, what happens to students after they leave the anatomy classroom? In their training, medical students spend 4 to 12 years navigating a shifting environment of hidden, null, or explicit curricula that have a significant impact on their attitudes and character.[7–10] If professionalism issues—such as encountering mortality, enacting contracts with society and those who are most vulnerable, and upholding scientific excellence—are worthy of being taught in anatomy courses, then the same must be true in other basic science courses in an integrated, longitudinal professionalism curriculum.

Some argue that the professionalism challenges that students face in other basic science courses are not as intense as those that they face in anatomy courses, such as the dissection of human tissue, which may be difficult for students to process emotionally. Whereas the examples in anatomy are overt and perhaps predictable, students are exposed to similarly powerful situations in other basic science courses as well. Moreover, student learning suffers when professionalism is not addressed in the later basic science courses, as professionalism education effectively becomes a "null curriculum,"[11] one that teaches students to compartmentalize

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professionalism questions so that they can be addressed in the anatomy classroom or during dedicated professionalism course work. What lesson is learned, for example, when students are taught that gallows humor is inappropriate during dissection, yet the same behavior is allowed when viewing samples during a pathology course? What lesson is learned when a preserved human brain does not generate discussion the same way that a whole, preserved human body does? What lesson is learned when there is no discussion of physicians' societal responsibilities during a lecture on sexually transmitted infections?

As a medical student, I discussed professionalism challenges in my first-year anatomy course, during which my teachers encouraged and promoted discourse on medical professionalism. Looking back as a fourth-year student—having seen firsthand the necessity of practicing professionalism in clinical contexts—I have noted analogous opportunities for professionalism education in my other basic science courses. Although these courses presented challenges similar to those found in my anatomy course, the curricula rarely addressed them. My medical professionalism education was effectively put on hold during those middle two years—The environment of awareness that I had cultivated during anatomy was lost. In this Perspective, I summarize the relevant literature as I highlight specific professionalism challenges in anatomy and discuss how they are addressed by anatomy educators. Then I provide analogous examples of opportunities to teach professionalism in other basic science courses. I have used Slotnick and Hilton's[5] definition of "what professionals do" (i.e., exercising "sophisticated reflective judgment" and "principled ethical reasoning") as a guiding, operational definition of professionalism.

Encountering Mortality

The most immediate professionalism challenge in anatomy is a medical student's confrontation with mortality in the dissection laboratory. This early contact with death is a provocative life event[12–14] that has long been known to trigger a number of defense mechanisms in first-year medical students, some

of which are antithetical to medical professionalism.[15]

Students' reactions to dissection may include using gallows humor as a vehicle both to navigate the existential stresses of the anatomy laboratory and to engage in emotional socialization with classmates,[16] which may allow students to gain a greater sense of emotional control by the end of the course.[17] Anatomy educators have recognized that to build an environment of awareness to address this issue, students' feelings may be redirected to literary and artistic reflections on death through a humanities co-curriculum, leading to more appropriate management of their reflections on mortality.[18–20] In addition, feelings of mortality engendered in the process of dissection can prompt students to reflect on the relationship of their lives to their chosen profession, which many historical anatomists recognized. Andreas Vesalius, for example, included in one of his artfully designed illustrations "*Vivitur ingenio, caetera mortis erunt*" or "Genius lives on, all else is mortal."[21] Thus, not only must students learn to cope with the emotional stress caused by dissection but they must also reflect on their limited life spans as the boundaries within which they work. The literature provides evidence that reflection is a component to professional behavior that students should begin practicing early in their careers.[22,23] Dissection has also been recognized as an opportunity for medical students to add a humanistic approach to their studies, and many have attempted to call attention to this challenge.[3,24,25] Such an approach allows students to relate to the mortal aspects of the human condition rather than distance themselves through the unprofessional traits of cynicism and overzealous scientific detachment.

Students also encounter issues relating to mortality in other basic science courses. Autopsy experiences during a pathology course, for example, offer students subtle exposure to situations, such as the use of preserved human tissue sections in lecture, that may make their own emotional demands on students. Students should ask themselves whether or not working with parts of the human body, such as whole organs or sections, demands

similar professional and emotional responses to confronting a cadaver. Does a brain preserved in formaldehyde deserve the same degree of existential consideration as a body preserved similarly? Furthermore, tissues often tell stories of death and disease that require some emotional processing—a section of human heart that demonstrates alcoholic myopathy recounts a story of human frailty. Medical students may interpret the story this tissue tells through the lens of biological signs and processes[26] or, more fruitful to them as humanistic medical professionals, through the lens of suffering and frailty. Medical microbiology also offers subtle examples—In studying infectious diseases, students are presented with a litany of deadly epidemics throughout history. In such strictly biomedical course work, humans become things or numbers.[26] In addition, medical students may view images of rabies victims tied to their gurneys. Their professors may tell them that, at this stage of the disease, the human being they are seeing is guaranteed to die. Silence on the human dimensions of this suffering invites the formation of a cold, clinical attitude in students. Such recurring themes on the fragility of human life deserve reflection. Feelings of mortality are not just a subject for the dissection laboratory; they must be brought forward during other basic science courses as well to cultivate an environment of awareness in medical students around professionalism challenges.

Enacting a Contract With the Vulnerable

Beyond inviting students to consider mortality, anatomy dissections place other emotional and professional challenges before students. The literature suggests that medical students undertaking human dissection peripherally mimic, with their cadaver donors, physicians' contracts with those rendered vulnerable by illness.[5,27] Indeed, treating a student's cadaver as his or her first patient is a common theme in the literature.[28–31] During dissection, students begin to practice the responsibilities of confidentiality and respect customarily practiced by physicians.[32]

Respect for the donor's body is an issue with which students contend, and its practice is a skill relevant to medical professionalism.[22,23] Students may be most visibly troubled by the roughness of dissection, and they may question whether they are upholding the respect that the vulnerable deserve by partaking in this act. Osteoporotic donors' bodies are occasionally damaged by this rough handling, and anecdotal evidence indicates that students feel profound dismay at the trauma that these cadavers suffer during dissection.[24,33] Students seem aware that they form a special contract with the vulnerable through dissection, and holding discussions is an excellent option for elucidating students' views on what role respect plays in medical professionalism.[24] Additionally, some anatomy educators have reported that breaches of confidentiality in the dissection laboratory present learning opportunities in professionalism and that they bring up these instances in discussion for students to reflect on professional behavior and confidentiality.[34] Likewise, respect for the deceased is a regular topic of discussion in dissection laboratories, and a number of programs explore with students what behavior is appropriate when handling human remains.[24,35] Some educators encourage students to reflect on respect by subtly shifting from using the terms "cadaver" and "corpse" to "donor," thereby implying personhood rather than dehumanized objectification.[35]

Analogous challenges are found in other basic science courses as well. Students could address issues related to respect and confidentiality during a pathology course, where the handling of autopsy specimens figures prominently. Many of the same issues that students face when dealing with body donors also arise when dealing with donors of any human tissue and provide opportunities for professionalism education. Of particular interest are such cases as that of Henrietta Lacks, from whom researchers derived the "immortal" HeLa cell line and whose story begs a more nuanced discussion of consent, race, and education in the practice of medical science.[36] A medical microbiology course also presents interesting professionalism challenges with regard to respect and patient confidentiality, such as students' consideration of sexually transmitted infections. In addition, neurology educators share a responsibility to expose

students to questions about comatose patients and brain death, such as the physicians' duties to humanely care for and respect these most vulnerable patients, as well as the ethics of withdrawing life support.

Enacting a Contract With Society

Scholars interpret professionalism, including physicians' privilege and responsibility to society, as a mechanism by which physicians enter into a social contract with the public.[37] Western societies accept and expect that medical professionals in their nations engage in the dissection of human material for the sake of improving the body of medical knowledge. In the past, the dissection of human material bore a profound stigma in many of these societies.[38] The burden of "donation" was assigned to criminals and indigent hospital inmates for centuries; through this practice, medical professionals held a kind of power over the oppressed and marginalized.[38,39] Through an arduous process of cultural change, voluntary body donation programs in North America and Europe came to replace such Dickensian measures,[40] but this history illustrates a time when the medical profession breached its social contract and betrayed a vulnerable sector of society. Students who consider the history behind the anatomical sciences may contemplate whether such events are examples of failed medical professionalism. They also may ask themselves why they are accorded the privilege of dissecting human material.

In their discussions of professionalism, anatomy educators have focused somewhat less on these questions, though some medical humanities curricula have sought to draw students' attention to anatomy's historical role in enacting physicians' social contract.[41] Educators seem to find the question complex and debatable whether dissection's pedagogical benefits outweigh its societal costs.[42–45] Answering this question also invites medical students to discuss society's expectations of them in exchange for the privilege of dissecting human tissue.

There are similarities to these issues in other disciplines as well. In a pathology course, for example, medical students have the privilege of dissecting human

bodies and perusing specimens resected from dead or dying patients, which can easily raise the same questions regarding social contracts. Other disciplines may similarly address physicians' privileges and responsibilities to society—Learning pharmacology could provoke discussions of clinical trials, how they are funded and performed, and who reaps the rewards of successful research programs. Similar questions arise in medical microbiology courses when conducting vaccine research. In psychiatry, professors and students could discuss numerous issues pertinent to professionalism, such as physicians' duties to balance patient and societal safety, to determine physicians' capacity for decision making, and to debate institutionalizing patients without consent.

Autopsy: To See for Oneself

The process of human dissection is one of discovery and insight. The word *autopsy* comes from the Greek word meaning "to see for oneself"—precisely the means by which students are trained as burgeoning medical professionals in the dissection laboratory. Galen described this venture: "if anyone wishes to observe the works of Nature, he should put his trust not in books on anatomy but in his own eyes."[46] As medical students engage in a tactile exploration of the human body, they implicitly explore the foundations of medical knowledge and the medical profession's obligations to scientific excellence.

Conducting an autopsy offers physicians the opportunity to think critically and extend the fields of medicine and biology. Training students to espouse these qualities and habits-of-mind is essential to producing high-quality medical professionals.[47] In effect, medical students, through their own efforts in the dissection laboratory, repeat the same historical arc of awe, curiosity, and rationalization of the body as did their forebears. They also learn to question their own assumptions and confirm what they learned from their textbooks through direct experience. The value of direct experience in discovery is best described by Jacobus Sylvius in his 1555 *Manual of Anatomy*:

> It is much better that you should learn the manner of cutting by eye and touch than by reading and listening. For reading alone never taught anyone how to sail a

ship, to lead an army, nor to compound a medicine, which is done rather by the use of one's own sight and the training of one's own hands.[48]

Other basic science courses may foster such professionalism training by engaging students in the acts of seeing, doing, reflecting, and using a personal lens. Autopsies in pathology offer students the opportunity to discover a patient's cause of death through direct observation. Nephrology courses may require students to undertake a 24-hour urine collection to examine their own kidney function. Pulmonology courses may encourage students to undergo spirometry to observe and correlate such values as tidal volume, minute ventilation, vital capacity, etc. Medical microbiology courses may require students to culture bacteria on agar plates and stain slides. Such basic science courses take the additional step beyond merely teaching scientific knowledge—They teach students the principle of *autopsy*, seeing for oneself. In doing so, they offer students opportunities to further their medical professionalism education. In this sense, educators should grant laboratory sections a certain degree of protection during ongoing curriculum revisions, given that they are an important venue for students to engage in seeing, doing, and reflecting with a personal lens on aspects of medical science. Alarmingly, recent evidence indicates that, even in anatomy, such practical course work is being cut.[49,50]

The Potential for Longitudinal Professionalism Education

The anatomical sciences are ideally situated to promote professionalism education; perhaps this is the reason why anatomy educators are advancing this effort in the basic sciences. Historically, all medical practitioners have encountered professionalism challenges in the course of their work, yet the practice of these sciences rarely required student participation in their daily struggles. Medical schools in the past often placed barriers between the lecture hall and real-life situations, except in the case of anatomy. Performing a dissection, the traditional method of learning anatomy, required students to learn the skill sets practiced daily by anatomists, thus providing no theoretical division between lecture and practice. Recently,

this barrier between education in other basic sciences and clinical practice has been somewhat deconstructed through the use of simulation and standardized patients to give students a head start on the clinical years, perhaps making the need for medical professionalism education in the preclinical years more relevant than ever before.

For professionalism to be a living discourse between students and faculty, a truly longitudinal environment of awareness must take shape. Compartmentalization of professionalism education creates a null curriculum,[11] suggesting to students that the subject is only viable in one or two disciplines of medical science. In contrast, "educational continuity," a form of longitudinal, integrated learning, has been successful at producing physicians who are dedicated to professional and humanistic values.[51–56]

Recognizing opportunities to teach professionalism in basic science courses other than anatomy is an important first step in creating educational continuity. Educators in these other disciplines may extend the means by which anatomy educators have addressed professionalism challenges to cover these analogous "lost opportunities" in their courses. Others have called specifically for this increased emphasis on professionalism education in other basic science courses.[57,58] Furthermore, creating this system of definitive professionalism education may be accomplished by developing regimented professionalism modules or by simply encouraging educators in the basic sciences to subjectively discuss the relevant professionalism issues throughout their respective courses. I personally believe that the latter will be more effective as professionalism education suffers under compartmentalization. Rather than relegating professionalism education to specified hours or days during the curriculum, I recommend that it be present throughout every lecture and laboratory session. Basic science educators then can follow the example of anatomy educators in assessing and providing feedback to students on their professionalism performance.[59,60]

Regardless of their method, educators in basic science courses should encourage students to avoid decontextualized memorization of scientific data and, instead, foster learning in preparation

for practicing in a world where medicine interfaces with cultural norms, politics, and society. As many medical schools reform their curricula to emphasize medical professionalism education, these true opportunities for developing the physicians of tomorrow must not be overlooked. Students must remember that professionalism continues as they rinse their instruments, cover up the cadavers, and step out of the dissection lab into the real world of medical practice.

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The Challenge of Promoting Professionalism Through Medical Ethics and Humanities Education

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Abstract

Given recent emphasis on professionalism training in medical schools by accrediting organizations, medical ethics and humanities educators need to develop a comprehensive understanding of this emphasis. To achieve this, the Project to Rebalance and Integrate Medical Education (PRIME) II Workshop (May 2011) enlisted representatives of the three major accreditation organizations to join with a national expert panel of medical educators in ethics, history, literature, and the visual arts. PRIME II faculty engaged in a dialogue on the future of professionalism in medical education. The authors present three

overarching themes that resulted from the PRIME II discussions: transformation, question everything, and unity of vision and purpose.

The first theme highlights that education toward professionalism requires transformational change, whereby medical ethics and humanities educators would make explicit the centrality of professionalism to the formation of physicians. The second theme emphasizes that the flourishing of professionalism must be based on first addressing the dysfunctional aspects of the current system of health care delivery and financing that undermine the goals

of medical education. The third theme focuses on how ethics and humanities educators must have unity of vision and purpose in order to collaborate and identify how their disciplines advance professionalism. These themes should help shape discussions of the future of medical ethics and humanities teaching.

The authors argue that improvement of the ethics and humanities-based knowledge, skills, and conduct that fosters professionalism should enhance patient care and be evaluated for its distinctive contributions to educational processes aimed at producing this outcome.

Professionalism is an integral component and goal of medical school and residency education. Over the past 13 years, the Association of American Medical Colleges (AAMC), the Liaison Committee on Medical Education (LCME), and the Accreditation Council for Graduate Medical Education (ACGME) have spearheaded educational reform in professionalism.[1–3] In 2011, the Project to Rebalance and Integrate Medical Education (PRIME) invited a group of U.S. scholars and educators to improve medical professionalism education through sustained dialogue with these organizations.[4]

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This national pedagogical collaboration aims to identify more effective roles in medical education for medical ethics and humanities, disciplines essential to the professional formation of medical students and residents. For our definition of medical ethics and humanities, we refer the reader to our earlier articles that lay out the four categories of ethics, history, literature, and visual arts (and their respective disciplines) that promote professionalism in medical education as a contemporary vision of Abraham Flexner's view of humanities in medicine.[5,6] "Professional formation" is the mastery of the fund of knowledge and skills, and the cultivation of professional virtues, essential to the ethical concept of medicine as a profession. This concept requires physicians to make three commitments: (1) to become scientifically and clinically competent by submitting to the discipline of the deliberative (evidence-based, rigorous, and accountable) practice of medicine; (2) to protect and promote the patient's health-related interests as the physician's primary concern and motivation, keeping

self-interest systematically secondary; and (3) to maintain, strengthen, and pass on medicine to future physicians, patients, and society as a public trust, rather than viewing medicine as a self-interested merchant guild that makes protecting the economic, social, and political interests of physicians paramount.[7]

The PRIME Project grew out of earlier work by the authors (D.J.D., L.B.M., SW) that focused on the Flexner Report and Flexner's writings on the essential nature of humanities education.[5,6] In May 2010, PRIME I invited educators in ethics, history, literature, and the visual arts from U.S. medical schools to review past educational efforts, accomplishments, and challenges associated with medical ethics and humanities, and to understand how these efforts can promote professionalism.[8] PRIME I created five questions for exploration by PRIME II, and these were circulated to PRIME II participants (see List 1). PRIME II was the next iterative, qualitative phase prior to the 2012 National PRIME Conference. Each PRIME II faculty participant

List 1

Probe Questions Circulated Prior to Convening the Project to Rebalance and Integrate Medical Education (PRIME) II Workshop, May 2011

1. Which medical school learning objectives—especially, but not limited to, professionalism—does study in the medical ethics and humanities support?
2. How should study of medical ethics and humanities be improved so that it more effectively and demonstrably contributes to the achievement of medical school learning objectives?
3. Which residency learning objectives—especially, but not limited to, professionalism—does study in the medical ethics and humanities support?
4. How should study of medical ethics and humanities be improved so that it more effectively and demonstrably contributes to the achievement of resident and fellowship learning objectives?
5. How should study of medical ethics and humanities be improved so that it more effectively and demonstrably contributes to and provides different ways of understanding the achievement of medical school and residency learning objectives defined/refined as a result of this critical appraisal?

was assigned to respond to two of the questions. The goal of PRIME I and II was to use qualitative methods to survey the landscape for education reform in professionalism in the National PRIME Conference in 2012.

The PRIME II invitation-only workshop in May 2011 engaged medical educators in ethics and humanities and the leaders of accreditation organizations to forge a common vision of the future of professionalism education. For PRIME II, the participants from PRIME I were joined by the educational stakeholders of AAMC, ACGME, and LCME to discuss the future of medical education in medical ethics and humanities, challenges that could potentially undermine these efforts, and strategies for responding to these challenges. In this article, we share the themes identified during PRIME II in an effort to inform discussion about next steps.

The themes we present here were identified using qualitative methods. All PRIME II Workshop plenaries, panels, and discussions were audio recorded (with the participants' permission) and then transcribed. Project leaders (D.J.D., L.B.M., S.W.) analyzed the resulting transcript, with inductive qualitative organization into meaningful themes and subthemes.[9] The Project Leaders negotiated the list of themes and subthemes into a master list, and all PRIME II participants circulated and edited the list for validation.

Themes for the Future of Medical Education in Medical Ethics and Humanities

On the basis of our analyses of the PRIME II discussion, we offer three overarching themes and various subthemes for the future of medical education in medical ethics and humanities.

Transformation: Professionalism education requires transformational change

Medical ethics and humanities teaching should contribute to leading and critically assessing transformative systemic change in medical student and resident education by making explicit the central role of individual professional formation to the lifelong provision of excellent and humane patient care. Medical ethics and humanities pedagogy is fundamental for the development, implementation, assessment, and continuous improvement of professional formation.[8] In the absence of physician leadership based on professionalism, change in the organization and delivery of health care in the United States could become aimless, possibly jeopardizing all patients. Medical ethics and humanities curricula should incorporate assessable goals of medical education that promote the continuous development of professionalism in the physician's lifelong learning.[10,11]

We recommend that such teaching should have five components. First, an effective medical ethics and humanities curriculum builds on what students bring to medical school, especially their prior studies in humanities, informed by work in the social and behavioral sciences. Second, the goals and outcomes of medical ethics and humanities teaching should emphasize professionalism by explicitly linking educational outcomes to the General Competencies, especially

Professionalism.[8] Third, medical ethics and humanities education should synchronize with what students are learning in the basic and clinical sciences and with what residents are learning in their rotations. Fourth, teaching must be assessable for its ability to promote professionalism (per the rubric of LCME and ACGME). Fifth, medical ethics and humanities teaching materials need to be readily understandable and relevant for the learner in order to promote professionalism education.

PRIME II participants emphasized that educational outcomes in ethics and humanities should be neither solely quantitative nor reductionistic (i.e., using simplistic or overly discrete behavioral metrics). Reliance on observable behaviors toward professionalism is important but insufficient, as the acquisition of professionalism skills and behaviors through medical training and practice is incremental, thematic, and individual for each learner. Professionalism requires a conceptual grasp of the virtues and habits of mind that make the commitment to intellectual and moral excellence in medicine routine. Qualitative assessment strategies need to be developed that address these nonquantifiable aspects of medical ethics and humanities teaching.[12,13] Educators need to help learners self-identify and promote incremental growth of professional virtues through critical reflection on the values, attitudes, and behaviors requisite for excellent patient care.[14–18] Learners need to appreciate that professionalism entails a lifelong commitment to internalizing and adhering to the standard of providing safe, competent, patient-centered care.[19,20]

Although medical ethics and humanities educators will need to agree on common goals and outcomes, pedagogical methods in medical education venues will necessarily vary. The LCME purposefully refrains from dictating how its standards are to be achieved in undergraduate medical education. Similarly, the ACGME does not require uniform teaching methods, and seeks quality improvement adaptive to the mission, context, and resources of each individual residency program; this work has already resulted in specialty-specific quality improvement models.[21–24] Milestone assessment will not be exclusively quantitative, and it

should not focus on minute behavioral skill assessments. Qualitative, thematic development of each learner's abilities and comportment (i.e., demonstrated attitudes and behaviors) will also be emphasized. The overarching goal in accreditation is to set the stage for every resident physician to be committed to continuous, progressive development toward mastery of professional attitudinal, behavioral, and communication skills to care for patients.

Professionalism education entails not only knowledge and skill building but also a mature attitude and comportment based on patient-centered values. These latter aspects of professionalism are often considered "humanistic," in that they promote the actualization of *being* a professional with sound communication and behavior. Explicitly incorporating medical ethics and humanities teaching into medical education allows each learner to enhance his or her abilities of observation, introspection, reflection, and critical thinking. These skills better enable learners to become caring health care professionals, with sophisticated, clinically responsive insight into the suffering of patients and a willingness to selflessly ameliorate patient suffering.

The integration of ethics and humanities education into professionalism education therefore needs to include humanistic skill building (e.g., in interpersonal and interprofessional communication), reinforced longitudinally throughout medical education. This integration should be present throughout basic science courses and laboratory work, clinical rotations, and residency education (but not so subsumed in pedagogy focused on science and technology that its relevance is lost on the student). Role modeling is an essential part of professionalism, in that students learn from peers, residents, staff, and faculty. The role of medical ethics and humanities educators is to provide learners with texts and images of both positive and negative clinical role models and identify their defining characteristics. Learners will thus be able to translate and adapt aspects of admirable role model interactions into particular clinical situations while avoiding the pitfalls of unprofessional role models.[25–28] Our learners are intelligent, with virtues they bring from their prior life experiences

to their development as physicians. Yet, educators in ethics and humanities need to build on these life experiences to teach critical thinking skills and professional behavioral responses to future challenging clinical moments of patient care.

The necessary prerequisites for these educational changes to occur include trained faculty, a facilitative environment, and insight into how to make the cultivation of professionalism relevant. Educators need to integrate the natural and life sciences and the behavioral and social sciences in a coherent way for learners in order to lay a foundation for professionalism that medical ethics and humanities education can promote. Learners will thereby successfully integrate professionalism through their cultivation of professional virtues and comportment and translate these into analytic, reflective, and social skills that are essential to excellent patient care.[15]

Question everything: Dysfunctional aspects of health care delivery and financing undermine medical education and require fundamental reform

The negative elements of a health care delivery system that too often falls short on quality and is increasingly financially unsustainable require reform to improve the educational environment, thereby better serving patients. This theme emphasizes that the current financing and delivery of health care create contradictory incentives for physicians and health care organizations. Reducing hospital length of stay independent of improving the quality of patient care, for example, and incentivizing physicians and health care organizations to cost-shift in response to the power of payers to set prices, each create powerful economic conflicts of interest. These effects have a negative, dissonant impact on both learners and educators, distorting and even undermining professional formation in the medical education environment. Students, residents, and practicing physicians realize that their learning environment leads to the development of negative personality characteristics. Some, in fact, may even lament, "I don't like who I've become." The culture that exists in some of our health care institutions and their allied educational institutions has the potential to suppress rather than

support the empathy and humanistic qualities of professional physicians.[29,30]

Continuous health care system reform is the first step toward humanizing both institutions. The PRIME panel and academic leaders contend that the stress of the current environment on our learners can cause dysfunction of the individual professional, impeding one's ability to acquire and incorporate knowledge and skills essential to professionalism. Part of the remedy must consist of having administrators, teachers, and medical learners become part of a dramatic solution to address the dysfunctional aspects of the current medical education system and the delivery of health care, beyond minor incremental "patches" to existing problems.

Yet, we acknowledge that education toward professionalism cannot single-handedly rectify the ills that affect our medical education and health care systems. For ethics and humanities to be a catalyst for system change, future improvement must be predicated on how the individual professional is affected by and can have an effect on the system. Each learner must have a firm understanding of health care system inequities, with enhanced training on the ethical nuances of justice in health care delivery. Learners must also grasp how the virtues of compassion and courage, and the accompanying affective aspects of comportment, advance the cause of patient care. Each practitioner who is trained in ethics and humanities is thereby better able to recognize, remedy, and become a catalyst for change now and in the future by leading change that sustains physicians' lifelong commitment to professionalism.

Learners need to be taught how to respond effectively to the deleterious features of this system, advocate for its improvement, and become professionally responsible and effective agents for the patient's benefit.[17,20,31,32] Medical ethics and humanities can equip students to develop a historically informed, ethically rigorous critical attitude to the current organization and financing of medical care with the goal of improving health care practices and patient care. Identifying the relevance of these topics is the essential task of the educator. Board

certification examinations need to balance aspects of medical ethics and humanities with the requisite science and technology of clinical care. Medical learners need to appreciate that mastery of knowledge and critical thinking skills of medical ethics and humanities is essential to developing their sustained ability to assess their learning and practice environment, identify aspects of it that either promote or undercut professionalism, and strengthen the former while eliminating the latter. The unique critical skills of ethics and humanities will equip our students and residents to be professionally adaptive to the future organization and financing of health care, whatever they might become. This process can best start with a critical appraisal of both the formal and hidden curricula and their conscientious reform, using medical ethics and humanities teaching.[8]

Unity of vision and purpose: Ethics and humanities educators must have shared goals

Ethics and humanities educators must collaborate to promote methods of professionalism education and identify their role in its teaching. This theme underscores the pedagogical responsibilities of medical ethics and humanities educators, especially in two domains.

The first domain of pedagogical responsibility is instrumental: Identify assessable contributions of medical ethics and humanities curricula to the goals and objectives of core competencies of professionalism. To fulfill this pedagogical responsibility, medical ethics and humanities educators need to unite, holding themselves to the same standards of accountability as their colleagues in basic and clinical sciences. Those resistant to change should recognize that LCME and ACGME have introduced outcomes-based expectations for professionalism in medical education that all medical educators must satisfy.[2,3] Methodologies that employ multiple teaching and assessment techniques call for educational research to ascertain what successfully promotes the critical thinking skills and behaviors of professionalism. High-quality, relevant education promoting professionalism is essential to its success. For instance, some learners report that there is too much professionalism education in

responses in the AAMC Graduation Questionnaire.[33] This phenomenon could be related primarily to the placement, quality, or relevance of content of medical ethics and humanities curricula. Future qualitative and quantitative empirical research should be undertaken, and the results should be used to enhance the relevance of ethics and humanities teaching in medical education. For example, it may be ascertained that course work in medical ethics and humanities should be designed and presented as complementary and integral to basic science teaching.

The second domain of pedagogical responsibility addresses how medical ethics and humanities faculty need to articulate a shared vision of how such education promotes professionalism. Our effectiveness will be dependent on how medical educators see themselves and are seen within the system that requires improvement. This vision will need to reconcile differences about the purpose of this teaching regarding its intrinsic value, its instrumental value, and how it uniquely contributes to the development of critical thinking skills in professionalism. Faculty need to develop coherent strategies for learner-based education at their own institution, including how to promote outcomes-based educational reform.

Medical ethics and humanities education and its contribution to professionalism may present a challenge in identifying assessable outcomes. Faculty need to develop an agenda for improving this education by creating resources built around these topics to be shared nationally by faculty. For these changes to occur, peer review, both within and between our environments, will stimulate self-reflection and growth at our institutions. The promotion of professionalism education requires support for faculty development, and the establishment of resource depositories for shared use.[34,35]

Progress

PRIME II set the stage for the PRIME National Conference on Medical Ethics and Humanities in Medical Education that was sponsored by Patrick and Edna Romanell Fund for Bioethics Pedagogy of the University at Buffalo and the University of

Louisville School of Medicine in Louisville, Kentucky, May 10 to 11, 2012.[4] The PRIME 2012 National Conference included faculty from PRIME 2011, including invited presentations by the leaders of AAMC, ACGME, and LCME.

The PRIME 2012 National Conference proceedings, currently in preparation, will address the "how" regarding the future of medical education toward outcomes-based professionalism education, with a particular emphasis on the relevance of medical ethics and humanities teaching to continuing education reform. Discussions of outcomes-based education included how qualitative and quantitative research can advance our educational goals in professionalism. Discipline-based working groups reviewed submitted abstracts in the areas of history, literature, medical ethics, and visual arts and discussed the strengths and weaknesses of efforts to date.

Promoting Professionalism for the Future

Leaders from AAMC, LCME, and ACGME helped facilitate a vigorous discourse at PRIME II on the future of medical education. All participants agreed that medical ethics and humanities education efforts should contribute to transformative change by connecting professionalism to outstanding, benevolent patient care. We also acknowledge that problems in the current financing and organization of medical education and health care negatively influence our medical learners, and that only simultaneous transformation in both medical education and our health care system will overcome challenges to professionalism. Further, unity of vision among educators in medical ethics and humanities will be needed to identify and eliminate these negative influences. This national conference highlighted the need for educators to collaborate toward the common goal of improved professionalism by being change agents at their home institutions, and encouraged coordination of these efforts. To that end, PRIME's national conference faculty and attendees founded the Academy for Professionalism in Health Care in the fall of 2012 with the purpose of supporting the development and maintenance of educational programs that promote professionalism in health care.[36]

Education in ethics, history, literature, and the visual arts can play an integral role in medical education in professionalism. Merging these disciplines into medical education will require better curricular integration, refined and improved teaching and assessment methods, and increased collaboration and interdependence among educators. PRIME will continue to pursue avenues of education reform to enhance communication among educators and accreditation organizations. The desired end point will continue to be the improvement of the knowledge, skills, and comportment that foster excellence in patient care by future generations of medical students and residents.

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Bushido and Medical Professionalism in Japan

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Abstract

Medical professionalism has become a core topic in medical education. As it has been considered mostly from a Western perspective, there is a need to examine how the same or similar concepts are reflected in a wider range of cultural contexts. To gain insights into medical professionalism concepts in Japanese culture, the authors compare the tenets of a frequently referenced Western guide to professionalism (the physician charter proposed by the American Board of Internal Medicine Foundation, American College of Physicians Foundation, and the European Federation of Internal Medicine)

with the concepts of Bushido, a Japanese code of personal conduct originating from the ancient samurai warriors. The authors also present survey evidence about how a group of present-day Japanese doctors view the values of Bushido.

Cultural scholars have demonstrated Bushido's continuing influence on Japanese people today. The authors explain the seven main virtues of Bushido (e.g., rectitude), describe the similarities and differences between Bushido and the physician charter, and speculate on factors that may account for the

differences, including the influence of religion, how much the group versus the individual is emphasized in a culture, and what emphasis is given to virtue-based versus duty-based ethics.

The authors suggest that for those who are teaching and practicing in Japan today, Bushido's virtues are applicable when considering medical professionalism and merit further study. They urge that there be a richer discussion, from the viewpoints of different cultures, on the meaning of professionalism in today's health care practice.

Medical professionalism has recently become a core topic in medical education,[1] which is reflected in a growing body of literature discussing curriculum development, teaching, and the evaluation of professionalism in physicians' development.[2] The physician charter proposed by the American Board of Internal Medicine Foundation, American College of Physicians Foundation, and the European Federation

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of Internal Medicine[3–5] is frequently cited as an authoritative document about professionalism. The charter's 3 principles (primacy of patient welfare, patient autonomy, and social justice) and 10 professional commitments[5] are widely endorsed by international professional associations, colleges, societies, and certifying boards. However, we believe that the discussion of professionalism should also be related to the world's different cultures and social contracts, respecting local customs and values even when they differ from Western ones.[6] This is because the role of the physician is subject to cultural differences and dependent on the nature of the particular health care system in which medicine is practiced.[6] As medical professionalism has mostly been considered from a Western perspective, there is a need to examine how the same, similar, or even different concepts are reflected in a wider range of cultural contexts.[7]

In Japan, professionalism is being discussed in a variety of forums, such as the Professionalism Committee of the Japanese Society of Medical Education and the Japanese Society of Internal Medicine.[8] Questions have been raised about how to translate the mostly Western concepts of professionalism presented in international publications into the Japanese setting as well as how to tell the international community about

unique Japanese concepts relating to medical professionalism. The very term *professionalism*, whose first meaning is "the conduct, aims, or qualities that characterize or mark a profession or a professional person,"[9(p930)] largely reflects a Western concept; there is no corresponding word in most Asian languages, including Japanese.[10]

To describe the views of some Japanese doctors on professionalism-related concepts, we have chosen Bushido as a value system, because it has much in common with Western virtue ethics; its meaning, "the way of the warrior," is comparable to that of professionalism. It is a historical Japanese code of personal conduct originating from the ancient samurai warriors. In this article, we introduce the concepts of Bushido, compare them with Western concepts of medical professionalism—as represented by the physician charter mentioned earlier—and present views of some doctors now working in Japan about the continuing relevance (and occasional nonrelevance) of Bushido to their medical practices.

The Concepts of Bushido

Background

Although there are many books written about Bushido, the one by Inazo Nitobe,[11] *Bushido: The Soul of Japan*, published

in English in 1900, is a classic that is highly referenced in the international community. Nitobe describes Bushido as the code of moral principles that the knights (samurais) were required or instructed to observe. It is likened to chivalry and the noblesse oblige of the ancient warrior class of Europe. As in the martial arts of judo or karate, Bushido has a basis in Buddhism, Confucianism, and Shintoism.[12] Though some cultural experts and scholars argue that the influence of Bushido on Japanese society has lessened,[13] others say that the spirit of Bushido remains in the minds and hearts of the Japanese people.[9,14] Although Bushido is not specific to medicine, some argue that it continues to influence the behavior of modern Japanese doctors.[15]

The seven principal virtues

The seven principal virtues in Bushido are rectitude (*gi*), courage (*yu*), benevolence (*jin*), politeness (*rei*), honesty (*sei*), honor (*meiyo*), and loyalty (*chugi*). Below, we describe each virtue in more detail. We have presented the virtues in the order given by Nitobe.

The first virtue, rectitude (*gi*), is considered the most fundamental virtue of the samurai. It is the way of thinking, deciding, and behaving in accordance with reason, without wavering. In a medical setting, this guides the doctor to what she or he should be doing; therefore, it is analogous to the concept of professionalism itself. It is also similar to the concept of altruism, as rectitude is usually meant as the antonym of seeking personal benefit. Furthermore, because the same Chinese character is used for rectitude and justice in Japanese writing, the concept of rectitude is also tied in with the concept of social justice. In an e-mailed survey of Japanese doctors that we carried out in 2012,* 117 of the 133 respondents (88%) agreed (by answering "strongly agree" or "agree") that *gi* exists in their daily practices. Representative comments are "It is the value of justice or morality for doctors," "I have sacrificed my private life because I am a doctor (so there is *gi* in me)," and "I would not work as a hospital doctor if I pursued financial benefit."

Courage (*yu*), the second virtue, meaning the spirit of daring and bearing (i.e., how one stands, walks, and behaves), is defined as doing what is right in the face of danger. In Bushido, the concept that righteous action speaks louder than words is highly valued. Whilst there is no analogous concept in the physician charter, *yu* can be understood to mean being unafraid to put the principles of professionalism into practice. Eighty-three respondents (62%) agreed to the existence of this virtue in their daily practices. Representative comments are "Doctors who went to rescue people suffering from the 2011 Great East Japan Earthquake and Tsunami are good examples" and "Recently, I find it difficult to practice *yu*, as patients became more and more demanding."

The third virtue, benevolence (*jin*), encompasses the concepts of love, sympathy, and pity for others and is recognized as the highest of all the attributes of the human soul. For doctors, that means practicing "medicine as a benevolent art," as one respondent to the survey expressed it. The concept of benevolence is expressed as "patient welfare" or "altruism" in the physician charter, though the Bushido concept *of jin* is more emotional and linked to empathy. In the survey, 123 respondents (93%) agreed that *jin* is alive in their clinical practices. Representative comments are "*Jin* is absolutely necessary!!!" and "There is no medical practice without *jin*."

Politeness (*rei*), the fourth virtue, is defined as respectful regard for the feelings of others. Nitobe[11] said that *rei* "suffers long, and is kind; envieth not, vaunteth not itself, is not puffed up; does not behave itself unseemly; seeks not her own; is not easily provoked; takes no account of evil." Although it may be one of the most influential concepts of the doctor–patient relationship in Japan, politeness is not described in the physician charter. We suggest that it is analogous to a commitment to maintaining appropriate relationships. In the survey, 111 respondents (83%) agreed that *rei* is important in their clinical practices. Representative comments are "I always try to show *rei* to patients," "I cannot do medical practice without *rei*," and "We must show *rei* as a member of society. It is a virtue that goes beyond medicine."

The Chinese character for honesty (*sei*) combines the characters for "word" and "perfect." The phrase *bushi no ichi-gon* means "the word of a samurai," which is a guarantee of truth. This fifth virtue is a counterpart to the commitment to honesty in the physician charter, though Bushido places greater emphasis than the charter on spoken words. Therefore, doctors in Japan may be embarrassed when they orally tell something important to patients and then have to change it (which happens in daily clinical practice). In the survey, 94 respondents (71%) agreed that *sei* is important in their clinical practices. Some representative comments are "In most cases, I tell my patients the truth even though it is a bad news," "*Sei* is fundamentally important," and (a contrasting view) "Sometimes the end justifies the means."

Honor (*meiyo*), the sixth virtue, is recognized as the ultimate pursuit of goodness. Nitobe[11] wrote, "The sense *of meiyo* could not fail to characterize the samurai, born and bred to value the duties and privileges of their profession." By writing that "Death involving a question *of meiyo* was accepted in Bushido as a key to the solution of many complex problems," Nitobe tried to explain the meaning of hara-kiri and seppuku; both are the classical types of suicide for samurai. We could draw a parallel with the concept of commitment to professional responsibilities, although there are some clear differences between the two; for example, doctors do not have to kill themselves as a result of unprofessional behavior. In the survey, 86 respondents (65%) agreed that *meiyo* is important in their clinical practices. Representative comments are "I feel *meiyo* to be a doctor," "I do not know.… I do not care much about *meiyo*, to be honest," and "Recently, I feel *meiyo* has lessened."

In contrast to the individualism of the West, the Japanese have long valued loyalty (*chu-gi*) to the needs and interests of the group (e.g., family or hospital staff), placing the group's needs above their own needs and interests. Bushido says that the interests of the family and the interests of its members are inseparable. Indeed, institutional loyalty is one of the factors that has encouraged Japan's health care workforce to display values of altruism in patient care. Yet in the survey, only 62 respondents (47%) agreed that *chu-gi* is important in their clinical

Table 1

Comparison Between the 7 Virtues of Bushido and the 3 Principles and 10 Commitments Written in the Physician Charter[a]

The charter	Virtues of Bushido						
	Rectitude (*Gi*)	Courage (*Yu*)	Benevolence (*Jin*)	Politeness (*Rei*)	Honesty (*Sei*)	Honor (*Meiyo*)	Loyalty (*Chu-gi*)
Principle							
Primacy of patients' welfare	X		X				X
Patients' autonomy	X						
Social justice	X					X	X
Commitment							
Professional competence	X						
Honesty with patients	X				X		
Patients' confidentiality	X						
Maintenance of appropriate relationships	X			X			
Improvement of quality of care	X						
Improvement of access to care	X						
A just distribution of finite resources	X		X				
Scientific knowledge	X						
Maintenance of trust by managing conflicts of interest	X						
Professional responsibility	X					X	

[a] To gain insights into medical professionalism concepts in Japanese culture, the authors compared the tenets of a frequently referenced Western guide to professionalism (the physician charter proposed by the American Board of Internal Medicine Foundation, American College of Physicians Foundation, and the European Federation of Internal Medicine) with the concepts of Bushido, a Japanese code of personal conduct originating from the ancient samurai warriors. The table presents an overview of this comparison.

practices. Representative comments are "I feel *chu-gi* to my boss and the hospital I am working for," "I weigh my personal benefit against the institutional one where I belong," and "Recently, I feel fewer and fewer doctors feel *chu-gi*."

Comparing Bushido and the Physician Charter

By comparing Bushido with the physician charter, we found that there are omissions, nuances, and blendings of words that create differences between the two in addition to the differences that are clearly there, which reminds us how meanings can be altered in translation and interpretation. Nevertheless, comparisons of Bushido and the physician charter can provide fresh insights into the understanding of professionalism. The charter calls for altruism from doctors, a concept that has a long tradition in Western thought.[16] The Japanese way of upholding the primacy of patient welfare is to practice a blend of rectitude, benevolence, and loyalty. Similarly, although the concept of social justice per se may not prevail in the Japanese health care system, the concepts of rectitude,

honor, and loyalty together represent social justice. For example, when these virtues work together within a universal health care system (i.e., one that covers everyone), they can motivate physicians to eliminate discrimination in health care.[17]

There are also several commitments in the physician charter that are not present in Bushido, because the charter describes medical professionalism, whereas Bushido describes a code of conduct for people in general. This difference can be seen in Table 1, which presents a comparison of the 7 virtues of Bushido and the 3 principles and 10 commitments of the physician charter.

Concepts in Bushido That Differ From Contemporary Views of Professionalism

Examples of differences

Although Bushido is intrinsically intertwined with the values of Japanese society,[2] it has concepts that differ from—and sometimes conflict with—contemporary notions of professionalism. Bushido does not address the autonomy of the individual, which

is one of the principles in the physician charter. This omission may encourage paternalistic relationships between doctors and patients in Japan; such relationships are increasingly considered unacceptable in Western culture. In the chapter on self-control, which is an associated virtue in Bushido, Nitobe[11] stated that the Japanese were required not to show their emotions to others, expressed in the phrase "He shows no sign of joy or anger." Although this behavior might be considered an appropriate trait in Japan, it can cause miscommunication between doctors and patients. Inequality between men and women is another example, rooted in Bushido, where the roles of women were classified as *naijo*, the "inner help" of the home. With the recent influx of women into Japanese medicine, such challenges as maintaining work–life balance (e.g., through flexible work arrangements) are transforming the traditional concept of Japanese work ethics and provoking intergenerational discussions that are shaping the present-day view.[18]

Factors behind the differences

Many factors account for differences between Bushido and the physician

charter. An important factor is religion. For example, although the social contract between medicine and society is very important in discussing medical professionalism,[6] the concept of a "social contract" is foreign to Japanese culture (and probably other non-Judeo-Christian cultures), as it implies a covenant based on Judeo-Christian principles. Another example: In Confucian cultures like Japan, young people are expected to show respect for elderly people. Demonstrating politeness (*rei*) to an older person calls for a type of deference on the part of a doctor that might not be seen in Western cultures.

The extent to which a culture values individualism is another factor influencing the professionalism of doctors.[19] Loyalty (*chu-gi*) motivates doctors to give greater weight to the interests of the group in cultures like Japan's that value a collective approach.

A final, and very basic, difference between the physician charter and Bushido is that the former is founded in an ethical system based on duty and rules, whereas Bushido is founded in virtue ethics,[20] which concerns the character of the actor. In ethical systems based on duties and rules, one judges whether a course of action is ethical or not according to its adherence to ethical principles, focusing on *doing*, whereas virtue ethicists judge whether an action is ethical according to the character trait the actor embodies, focusing on *being*. Virtue ethics has attracted increased interest in the field of general philosophy in recent years and has also entered into discussions about medical professionalism,[21] such as this one.

A Call for Multicultural Perspectives on Professionalism

While recognizing that Bushido was in full force at a particular time and place in Japanese history and culture and is by no means a comprehensive ethical system, we suggest that its concepts are applicable to discussions of medical professionalism for those teaching and practicing in Japan today, and merit further study. Given the pace of globalization, which can easily cause the hegemonic imposition of Western culture and discourage cultural diversity, we hope this article will encourage a richer discussion, from the viewpoints of different cultures, on the meaning of professionalism in today's health care practice.

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Transcendent Professionalism: Keeping Promises and Living the Questions

David C. Leach, MD

Abstract

Wynia and colleagues propose a definition of professionalism as a belief system by which to shape health care rather than a list of values and behaviors. The belief that professionalism is the best way to organize and deliver health care constitutes a promise to society. The notion that the medical profession as a whole as well as its individual members should be held accountable to standards of competence, ethical values, and interpersonal attributes developed, declared, and enforced by the profession itself is also a promise to society. The author argues that good promises offer a stabilizing influence over the inherent uncertainty in human relationships and may provide the ground for a lasting trustworthy relationship between the medical profession and society; however, the professionalism belief system itself is vulnerable if the promise is breached. The modern world has challenged the professionalism model of organizing health care, and individual practitioners as well as their professional organizations are seeking clarity about what professionalism means given current realities. This commentary reflects on these circumstances and provides some recommendations for developing a construct of professionalism.

> … have patience with everything unresolved in your heart and try to love the questions themselves … the point is to live everything. Live the questions now. Perhaps then, someday far in the future, you will gradually, without even noticing it, live your way into the answer.
>
> —Rainer Maria Rilke[1]

For physicians, professionalism expresses itself in all relationships, be they relationships with patients, with colleagues, or with society. As I write this each of those relationships is being challenged. Time constraints, issues of social justice, documentation requirements, interprofessional challenges, and a general and massive loss of societal trust in many institutions (e.g., governmental and financial institutions) have demanded clarity about what professionalism is and how medical

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practitioners and their related institutions can be both effective and faithful to the promises of professionalism.

In this issue, Wynia and colleagues[2] report on their work with the American Board of Medical Specialties (ABMS) attempting to define medical professionalism. Their work offers a foundational understanding of medical professionalism—that is, a definition that transcends the speculative idealism of lists of values and desired behaviors and considers professionalism to be the reason such lists are created. In their view, professionalism is a belief system about the best way to organize and deliver health care. The main belief in this system is that the public is best served when both the medical profession as a group and its members as individuals are held accountable to standards of competence, ethical values, and interpersonal attributes developed, declared, and enforced by the profession itself. It is a set of promises about the trustworthiness of both the profession as a whole and the individuals practicing in it. It attempts to clarify what the public and individual patients can and should expect from the medical profession and its practitioners.

I agree with the authors' definition and at the same time hope they are right. I use the word "hope" the way Parker Palmer[3] used it when he said:

> Hope is not the same as optimism. An optimist ignores the facts in order to come to a comforting conclusion. But a hopeful person faces the facts without blinking—and then looks behind them for the potentials that have yet to emerge—knowing that the human experiment would never have advanced were it not for the possibilities, however slim, that lie hidden behind the facts.

The potentials behind the facts in medical professionalism are compelling, yet the profession finds itself at a crossroad: Trust will either be eroded or strengthened depending on which path we take forward.

Hannah Arendt[4] argues that humans by their very nature are unreliable and that their actions have uncertain effects. These two factors make for unpredictability. In her view, promises offer a stabilizing influence and create the ground for lasting relationships with others; however, "(t)he moment promises lose their character as isolated islands of certainty in an ocean of uncertainty … they lose their binding power and the whole enterprise becomes self-defeating."[4(p244)] It is important to get the promises right. If medicine is to survive as a profession, it is important that its promises be clear to all and that both individuals and relevant medical organizations be held accountable for the promises.

But what constitutes a good promise? Good promises plan for the forgiveness that will be needed when the promise is broken.[5] In Arendt's view, promises have a companion faculty: forgiveness. Forgiveness, like promises, should be

taken seriously. It can repair human relationships and can help manage the irreversibility of some human actions. In the absence of forgiveness, promises remain vulnerable ideals. Progress has been made on forgiveness in medicine. Best practices, such as transparency, disclosure policies, formal apologies, analysis of error, and redesigning systems to be safer, help to make forgiveness possible, and, in some systems, to allow forgiveness to achieve the status of promises. The authors' definition of professionalism is silent on forgiveness and lacks specificity in its call for accountability. That task is left to ABMS as it develops a workable plan for clarifying the promises and preserving trustworthiness when those promises are broken.

As for the rest of us, what can we do to restore and preserve medical professionalism? Perhaps we can begin by accepting Rilke's[1] advice that we "learn to love the question" and over time to "live (our) way into the answer(s)." Living our way into the answers requires an appreciation of the organic nature of professionalism. Professionalism is not organically expressed by answering multiple-choice questions correctly, or even by responding correctly to simulated challenges, as helpful as those tools are. It is expressed in relationships with real patients and in the particular contexts in which practitioners work and learn.

A Hasidic story is relevant. This story was related by Jacob Needleman and published by Parker Palmer[6]:

> A disciple asks the rebbe, "Why does Torah tell us to 'place these words *upon* your hearts'? Why does it not tell us to place these holy words *in* our hearts?" The rebbe answers, "It is because as we are, our hearts are closed, and we cannot place the holy words in our hearts. So we place them on top of our hearts. And there they stay until, one day, the heart breaks and the words fall in."

Medicine is full of heartbreaking experiences for patients and their families, and for its practitioners. One thing we can do when confronted with human suffering is to "break our hearts" in ways that open the heart to professional values, in ways that let "the words fall in." Suffering can either harden the heart or, alternatively, can

open and expand the heart's capacities for compassion.

How can we develop the heart in our work? We might begin by working with human nature. All humans come equipped with three faculties: the intellect, the will, and the imagination. The object of the intellect is truth, of the will goodness, and of the imagination beauty. This applies directly to the work of medicine. The task of the good physician is to discern and tell the truth, to seek what is good for the patient and place it above what is good for the doctor, and to find beauty (i.e., harmony) in clinical judgments, harmonizing the best generalizable science with a deep understanding of the particular context of a given patient and making a judgment that is in fact creative and beautiful. Good professionalism is a habit, a habit that can be fostered by systematically answering three questions at the end of each day: how good a job did I do discerning and telling the truth, doing what was good for the patient, and making clinical judgments that were practical and wise?

To develop the habit of professionalism we need both solitude and community—solitude to reflect on and clarify what we did, and community to see if our conclusions hold up under peer scrutiny. We are all busy, and the demands of clinical productivity have compromised both our ability to reflect on and to have good conversations about our practices. Yet this gets right at the heart of our work: Reflective practice is not an option; it is integral to professionalism. In promising professionalism, we are in fact promising how we manage our time. It turns out that we each have 24 hours a day, and if we fail to align our time with our values we are destined to spend our time on an ever faster treadmill and will lose touch with the wisdom that makes our work fruitful.[7(p86)]

We can pay more attention to the work of professional formation. I favor the word "formation" over the word "education." Education implies the transfer of information; formation acknowledges the important role of context in shaping our professional development. Internal and external forces have profound effects in shaping our competence, values, and

interpersonal skills. Most gardeners would argue that it is overly simplistic to say that phosphorus fosters the development of roots while nitrogen fosters good foliage; nonetheless, there is some truth in the statement, and the analogy works in the case of professional formation. In medicine, foliage might be thought of as grants, publications, titles, learning new clinical skills and procedures, etc. Roots might be thought of as consisting of deeply held values and beliefs. Having spent most of my professional life engaged in the professional formation of residents, it seems to me that we spend most of our time encouraging good foliage while the roots are assumed to take care of themselves. We may need to examine the phosphorous/nitrogen ratio of our formation work.

Learning the right way to break our hearts, to deepen reflective practice, to find time for solitude and for good conversations, and to nourish our roots as well as our foliage both as individuals and as a profession requires that we recognize and create nourishing communities. We must develop an ecology that supports life—one that nourishes the deeply human in all of us, patients as well as practitioners. To do that, we must design systems that make it easy to develop these habits.

Medicine does not begin with ideals, but begins with the sensory observation of reality. From these observations a construct of professionalism can be developed. If the belief that professionalism offers the best approach to organizing health care is to make for a good promise to society, we must carry our observations and conclusions into the larger social conversation. Meanwhile, we can practice those conversations in our own hearts and in our own house. We can then live our way into the answers.

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More Than a List of Values and Desired Behaviors: A Foundational Understanding of Medical Professionalism

Matthew K. Wynia, MD, MPH, Maxine A. Papadakis, MD, William M. Sullivan, PhD, and Frederic W. Hafferty, PhD

Abstract

The term "professionalism" has been used in a variety of ways. In 2012, the American Board of Medical Specialties (ABMS) Standing Committee on Ethics and Professionalism undertook to develop an operational definition of professionalism that would speak to the variety of certification and maintenance-of-certification activities undertaken by ABMS and its 24 member boards. In the course of this work, the authors reviewed prior definitions of professions and professionalism and found them to be largely descriptive, or built around lists of proposed professional attributes, values, and behaviors. The

authors argue that while making lists of desirable professional characteristics is necessary and useful for teaching and assessment, it is not, by itself, sufficient either to fully define professionalism or to capture its social functions. Thus, the authors sought to extend earlier work by articulating a definition that explains professionalism as the motivating force for an occupational group to come together and create, publicly profess, and develop reliable mechanisms to enforce shared promises—all with the purpose of ensuring that practitioners are worthy of patients' and the public's trust.

Using this framework, the authors argue that medical professionalism is a normative belief system about how best to organize and deliver health care. Believing in professionalism means accepting the premise that health professionals must come together to continually define, debate, declare, distribute, and enforce the shared competency standards and ethical values that govern their work. The authors identify three key implications of this new definition for individual clinicians and their professional organizations.

A perennial challenge for every profession is to collectively establish and enforce professional standards.[1] This challenge came to the fore during a 2012 initiative of the American Board of Medical Specialties (ABMS) to develop a working definition of "professionalism."[2] The ABMS is the umbrella group for 24 U.S. specialty and subspecialty boards that certify individual medical and surgical specialists. The authors worked with ABMS leadership to create an operational definition that could serve as a foundation for member boards in their wide array of certification and

maintenance of certification activities. In doing so, the ABMS definition ended up approaching professionalism from a different vantage point than many other contemporary definitions, which generated some foundational insights about the nature of professionalism that might prove useful for organizations and individuals seeking to better understand and strengthen professionalism in health care.

Our initial approach was functional. The member boards are the assessment arm for lifelong learning among physicians, and the definition needed to be well suited to this responsibility and to the diversity of the member boards. But we also sought to address several broader questions: What is the purpose of professionalism, how does it work, and what does it entail?

Traditional Definitions

In a literature search and by surveying the member boards of the ABMS, we found more than 20 different definitions of professions or professionalism (some prominent examples are included in Supplemental Digital Appendix 1, http://links.lww.com/ACADMED/

A191). In reviewing these, we noted that a few others have also sought to frame the social functions of professionalism within a definition. Jordan Cohen and others have described medical professionalism as a tool, the "basis"[3] or the "means [to] fulfill the profession's contract with society,"[4] and Eliot Freidson called it "a set of institutions which permit members of an occupation to make a living while controlling their own work."[5] Still, many recent definitions do not address the foundational purpose of professionalism explicitly; instead, they focus on articulating a list of attributes, behaviors, commitments, obligations, principles, values, virtues, or other desirable traits of professionals.

Some definitions display both descriptive and normative components. These generally acknowledge some important descriptive characteristics of professional knowledge (extensive and complex), training (lifelong), and practice (difficult to assess). They then propose a set of shared values that the writers assert professionals ought to exemplify, such as compassion, justice, honesty, respect, altruism, and service. For purposes of assessment, the best of

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these definitions go on to articulate lists of measurable behavioral expectations derived from each proposed value.[6]

Problems With Definitions Based Primarily on Lists

These "list-based" definitions of professionalism are quite functional for teaching, measurement, and certification, yet in several ways they also risk obscuring the foundational purpose, functions, and demands of professionalism.

First, reducing professionalism to a list of desired professional principles, traits, or behaviors is akin to reducing the entire experience of cooking to checking off the grocery list while shopping. Professionalism requires behaviors, so a list of measurable professional behaviors is necessary, but the list, in and of itself, is not sufficient to define professionalism. Second, professionalism defined simply by a list of desired behaviors risks being misconstrued as a state that individuals can attain by checking off the elements of the list. Finally, defining professionalism as a list of personal attributes suggests that professionalism primarily is operationalized at the individual level, deflecting attention from the essential group activities that underlie professionalism, including the ongoing development and enforcement of professional standards that self-regulatory organizations like the ABMS must do.

A Better Way to Define Professionalism

Rather than comprising a list of desirable values and behaviors, we argue that professionalism transcends these; it is the *reason* for creating such lists and acting in accordance with them. In this light, professional behaviors should be recognized as derivative of the belief system of professionalism. Professionalism is not merely an accounting of what physicians promise to patients and society. At root, it is the motivational force—the belief system—that leads clinicians to come together, in groups and often across occupational divides, to create and keep shared promises.

The ABMS definition of professionalism, adopted in both long and short versions by a unanimous vote of the ABMS Board in January 2012, asserts that:

> Medical professionalism is a belief system about how best to organize and deliver health care, which calls on group members to jointly declare ("profess") what the public and individual patients can expect regarding shared competency standards and ethical values and to implement trustworthy means to ensure that all medical professionals live up to these promises.[2]

(The long version of the definition[7] and the background framing for the definition[8] are also available.)

Although behaviors are important for accountability, regulatory, and enforcement purposes, recognizing that professionalism is fundamentally a belief system about how groups ensure that their members are worthy of trust will enhance commitment, resilience, and adaptability as health practitioners navigate the ongoing challenges of publicly declaring and exhibiting professional behaviors, especially because we cannot anticipate all the behaviors the evolving health system might require.[6] This definition also leaves room for broader forms of professionalism as the health system encompasses more and different roles for a variety of health practitioners.

Perhaps most important, this definition draws attention to the primary function of professionalism in health care: ensuring that health professionals are worthy of patient and public trust. Achieving this purpose requires living up to the belief that professionalism is a realistic and desirable means of organizing and delivering health care; hence, this definition goes behind the veil created by lists of professional expectations and suggests *why* professional groups must both generate these lists and enforce them.

Implications of Defining Professionalism as a Belief System

Identifying professionalism as a belief system about how best to organize and deliver health care is not entirely new. The sociologist Eliot Freidson[5] called professionalism "the third logic" and compared it to alternative logics of markets and bureaucracies as ways to organize and deliver goods and services. The greater importance of this new formulation lies in several specific implications that it carries for individual practitioners and professional organizations.

First, defining professionalism as a belief system identifies foundational scientific and technical competency standards and shared ethical values as *equally important* and recognizes that both are within the purview of professionalism. Earlier definitions that focused on lists of values and character traits tended to conceive of professionalism as being only about ethical standards, so much so that "ethics" and "professionalism" often have been used interchangeably. There are hazards in conceptualizing professionalism as a separate area of competence, equal to ethics and distinct from practitioners' responsibilities to attain and maintain the technical and other skills necessary to provide quality care. The more professional groups recognize that technical, interpersonal, and values-based competencies make up interlocking sets of promises, all of which are required by professionalism, the more effective our training and assessment programs will be.

Second, because this new definition requires practitioners jointly to develop and declare collective public promises and ways to hold each other accountable, it calls explicit attention to shared accountability, to the legitimacy and effectiveness of existing self-regulatory mechanisms, to the public's key role in setting expectations for health professionals, and to the roles of professionals in the public sphere. In short, the unwillingness or inability of groups of professionals to govern their work effectively poses a fundamental challenge to societal belief in professionalism. The inability of individual practitioners to see professional mechanisms for establishing and enforcing shared standards as legitimate also poses an existential threat to professionalism. For example, the 24 U.S. member boards are operationalizing self-regulation to ensure the lifelong competency of physician diplomates through "maintenance of certification" programs.[9] Yet, a majority of respondents to a 2010 Web poll, and even some experts, did not endorse this self-regulatory mechanism.[10] Jointly developed professional standards require broad participation in the process, and public declaration ("professing") is bound to generate contentious discussions about policy and practice. Novel means of engaging more physicians, other health

professionals, and the public in this process, including through social media, might prove fruitful and, by the ABMS definition, would also buttress belief in professionalism as a legitimate means of organizing and delivering health care.

Finally, recognizing that professionalism is a normative belief system, and that its legitimacy is dependent on living up to its promise of ensuring that practitioners are trustworthy, forces serious consideration of what happens if professionals and their organizations fail to establish credible means of ensuring that practitioners are worthy of trust. Believing in professionalism means holding the conviction that medical professionals can come together to establish and enforce standards for competence and ethics, and that society is best served when health care is entrusted to these professionals. But not everyone believes in professionalism. In fact, there are prominent alternative belief systems about how best to organize and deliver medical care, including consumerism and other "isms."[11] This new definition calls attention to the fact that if professionalism fails to ensure trustworthiness, if the public no longer believes in professionalism, it can be revoked in favor of substitute belief systems that rely less on patient and public trust in health practitioners.

Believing in Professionalism Demands Collective Action

In sum, this new definition of professionalism, though created for the ABMS, offers guidance on questions facing all health practitioners and professional organizations that come together for the purpose of strengthening professional bonds. We opened this essay with three questions: What is the purpose of professionalism, how does it work, and what does it entail? We conclude that medical professionalism is a normative belief system about how best to organize and deliver health care. As such, professionalism should serve to ensure that practitioners are worthy of the trust bestowed on them by patients and the public. Most fundamentally, therefore, professionalism requires that health professionals, as a group, be ready, willing, and able to come together to define, debate, declare, distribute, and enforce the shared competency standards and ethical values that must govern medical work.

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Social Media and Medical Professionalism: Rethinking the Debate and the Way Forward

Tara Fenwick, MEd, PhD

Abstract

This Perspective addresses the growing literature about online medical professionalism. Whereas some studies point to the positive potential of social media to enhance and extend medical practice, the dominant emphasis is on the risks and abuses of social media. Overall evidence regarding online medical professionalism is (as with any new area of practice) limited; however, simply accumulating more evidence, without critically checking the assumptions that frame the debate, risks reinforcing negativity toward social media.

In this Perspective, the author argues that the medical community should step back and reconsider its assumptions regarding both professionalism and the digital world of social media. Toward this aim, she outlines three areas for critical rethinking by educators and students, administrators, professional associations, and researchers. First she raises some cautions regarding the current literature on using social media in medical practice, which sometimes leaps too quickly from description to prescription. Second, she discusses professionalism. Current debates about the changing nature and contexts of professionalism generally might be helpful in reconsidering notions of online medical professionalism specifically. Third, the author argues that the virtual world itself and its built-in codes deserve more critical scrutiny. She briefly summarizes new research from digital studies both to situate the wider trends more critically and to appreciate the evolving implications for medical practice. Next, the author revisits the potential benefits of social media, including their possibilities to signal new forms of professionalism. Finally, the Perspective ends with specific suggestions for further research that may help move the debate forward.

A surge of interest in debating the uses of social networking media—blogs and microblogs (Twitter), social networking sites (Facebook, Myspace), and content sharing sites (YouTube, Flickr)—is occurring among medical associations, medical educators, and researchers.[1] Despite emerging studies that suggest benefits of social media to enhance medical practice, the published literature remains dominated by strong concerns about its perceived abuses. These social media risks are typically framed in worries about medical professionalism, and social media use is discussed as a matter of professional ethics. Two examples of this framing are the new teaching modules focusing on avoiding risky behavior[2] and the codes of "e-professionalism"[3] that are proliferating in medical schools and hospitals.

This emphasis on risk avoidance, although important, can foreclose experimentation and the new possibilities afforded by social media. What may be helpful is to reconsider the dynamics at stake in the guidelines that regulate online behavior and to rethink online professionalism. Toward this aim, in this Perspective, I outline three areas for critical rethinking by educators and students, as well as by administrators, professional associations, and researchers. First I highlight concerns reported through recent reviews of social media use. Then I turn to a discussion of professionalism, outlining the current scholarly debates about its changing nature and the contexts that challenge notions of medical professionalism in social media. The online terrain itself and social media's built-in codes have also generated critical debates in digital research that are relevant here, and I have summarized this literature briefly. Next, I revisit the potential benefits of social media, including their potential to signal new forms of professionalism. Finally, the Perspective ends with specific suggestions for further research that can move the debate forward.

Examining the Evidence: Reviewing the Use of Social Media

The potential risks of using social media in medical practice are widely described.[4–6] Uppermost are concerns about compromising patient confidentiality and eroding public confidence in the medical profession through posting content that contains profanity, discriminatory language, and/or depictions of intoxication or sexually explicit behavior.[7] Some authors have warned that professionals' personal messages to friends via electronic media can be scrutinized according to codes of professionalism. Charges of unprofessionalism are also linked to blogs and tweets perceived to criticize employers.[6] There is general concern that a sense of disinhibition and anonymity in online environments may produce inappropriate postings, amplified immediately by the wide reach of the media.[4]

Responding to such concerns, some have argued for "e-professionalism"[3,8] as a distinct new paradigm requiring particular training and practice. Following this recent trend, new policies have explicitly set forth prescriptions for normative behavior to regulate and reduce social media use.[9] The General Medical Council of the United Kingdom, for example, released a national social media

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policy in April 2013[10] that emphasizes the prohibitive: Do not share identifiable information about patients anywhere, do not mix social and professional relations, and do not post anonymous material on any site if you identify yourself as a doctor. This "thou shalt not" orientation chimes with similar guidelines published by the American Medical Association in 2011. Medical education has responded with instruction aimed to prevent students from encountering social media hazards.[2]

Meanwhile, studies are now appearing that show how social media can enhance medical practice and how an online presence can foster collegiality and extend professional development and national/international linkages.[11–13] A range of social media experiments are creating professional–patient support groups and discussion forums, typically to facilitate self-care[14] or to disseminate public health information.[15] In their scoping review of this literature, Hamm and colleagues[11] conclude that while positive results tend to be reported, there is not yet much evaluation showing significant effectiveness. This lack of evidence may be one reason why social media hazards attract far greater attention than do its benefits.

Clearly, despite the proliferating studies of social media and medical professionalism, more research is needed—as is the case with any new area of practice. However, a broader problem exists: what some have called the "good and evil" framing of social media use.[16] Is the rush to regulation fully warranted? Are restrictions the most useful way to respond to problematic content posted online? Greysen and colleagues[17] conclude that physician postings of problematic content still constitute only a relatively small percentage of the total number of professional violations, and that these postings may be online manifestations of serious offline violations. That is, as a community, we might look more closely at whether problematic behaviors are a consequence of social media (and therefore best addressed through policing online activity and teaching medical students about online professionalism) or if, perhaps, the online environment simply makes more visible—and more public—some deeper problems in conceptualizing and actualizing medical professionalism.

Reconsidering Professionalism(s)

What is understood to be medical "online professionalism"? The emphasis in the social media literature falls on inappropriate individual postings. Here we see a view of professionalism as a matter of individuals making ethical decisions. The decisions are assumed to be rational, drawn from particular professional values that can be developed through education and disciplined through ethical codes.

Increasingly, this long-standing assumption is being critically reconsidered. Traditionally, professionalism has been represented as a normative value system, associated with trust, specialized knowledge, and the discretion needed to manage risk in public service.[18] However, critics argue that professionalism is not a way of being; rather, it is an ideological discourse used to ensure occupational containment and control.[19] For example, Lewis[20] highlights the fundamental conflict between the discourses of institutionalized medicine (the "profession") and of "professionalism" (which still tends to focus on the values and behaviors of individual clinicians). The *profession* emphasizes expert-driven, high-tech, high-cost interventions—sometimes at the expense of humanistic patient care, social justice, and democratic inquiry. However, *professionalism* makes the individual responsible for both altruistic care and duty to multiple authorities. The *professionalism* discourse works well as rhetoric to contain deep systemic conflicts by controlling individual practitioners and making these individuals primarily accountable for navigating the system to meet conflicting demands.

Furthermore, recent debates in medical professionalism have shown the inadequacy of singular frames of professionalism. These traditional frameworks simply cannot respond to multiple regulators, fast-changing evidence, and new forms of practice.[21] Growing research points to the pluralism of medical professionals' responsibilities.[22] Professionals must juggle obligations to institutional rules and efficiencies, to patients and families, to broad social needs, to medical science, to professional standards and regulatory codes, and to their own personal values. This "web of commitments" often necessitates what May[23] has called "legitimate

compromises." Doctors navigate a path of action that simultaneously balances concerns for different stakeholders without necessarily meeting the full expectations of any one. For example, in social media, a junior doctor may regularly blog about incidents from his anesthesia practice to illustrate common dilemmas for students and educators. The postings may cover effective strategies but may also reveal problems: entrenched routines, conflicting protocols, ineffectual hospital processes of organizing and resourcing, questionable staff competence, family issues. Even if all the material is anonymized and responses from colleagues and the public are overwhelmingly positive (both for making visible—and interesting—the complex dynamics of medical practice and for launching lengthy debates about best practices where there are conflicting priorities), such a blog can easily be dismissed as "unprofessional." Blog readers may be able to discover the identities of patients, providers, staff, or others; the physician may potentially contravene an employer's contract; blog postings may flout professional codes of ethics respecting colleagues; and blog content may compromise some patients' confidentiality.

Some experts have argued that entirely new understandings of professionalism are called for by these conflicts. For example, critical studies[24] show that universal lists of professional virtues are not fit for the contradictory demands of contemporary practice. Evetts,[25] a sociologist of professions, draws attention to new realities of professionalism being produced through the infiltration of markets into public institutions such as hospitals; that is, she shows how the conventional self-regulation and altruistic commitments defining a professional community ("occupational" professionalism) are being displaced and overridden by employers' demands and output measures ("organizational" professionalism). Increasingly, researchers are studying professionalism as a collective endeavor embedded within complex systems. For example, Martimianakis and colleagues[26] show how a simple direction to a clinical clerk from her emergency department supervisor that she conduct a quick internal vaginal examination of a pregnant patient in a busy hallway integrates multiple conflicts of professionalism: patient-centered care,

resource constraints, historic institutional conflicts and practice, hierarchies, gender and race, and the different roles demanded of doctors (problem solver, humanist, teacher, colleague, advocate, cooperative employee).

All of these issues speak to a more systemic, relational, and even pluralist approach to understanding professionalism. Certainly, the networked context of social media in itself challenges an isolated focus on the behaviors of individual professionals. Additionally, this fluid online context deserves a more critical examination before the medical community tackles the question of how to balance pluralist understandings of professionalism with important responsibilities of professional conduct.

Thinking More Critically About Social Media

Technology becomes valuable, meaningful, and consequential only when people actually engage with it in practice, according to digital work specialist Orlikowski.[27] The operation and outcomes of technologies such as new social media are not fixed or determining. They are always emergent through interaction with humans in practice: what Orlikowksi[27] calls the contingent intermingling of virtual spaces. In health care, the various online users interacting through social media—professionals, students and colleagues, patients, families, and other stakeholders—are not easily separated. Yet research in online medical professionalism does not often account for these interrelations.

Furthermore, there are important dynamics to consider critically, such as the algorithms and technological affordances built into the software itself. These create digital infrastructures that govern everyday practice: what Kitchin and Dodge[28] call "codespace." Existing histories of social media are already shaping particular forms of participation. Facebook algorithms and routines shape the content and style of exchange, as well as what is taken for knowledge. Van Dijk's[29] in-depth study of social media use shows how patterns of "friending," "favoriting," linking, trending, and following have come to shape broader cultural expectations for relationships. Notions of privacy itself are being reconfigured through online norms. These changing ideas of relationship, privacy,

and knowledge are bound to affect how patients and professionals engage online.

Those of us in the medical community also need to be more critical of assumptions that "openness," blurred boundaries, and connectivity are inherently good things. Users donate free labor to generate content that creates commercial profits for digital corporations, and user connectivity feeds corporate data mining.[30] From this perspective, social media participants can simultaneously be viewed as empowered agents and targets for exploitation. Further, the "digital divide" continues to complicate genuine online outreach to aging, low-income, or rural populations. These are broader issues that would be well worth examining with medical students. This sort of instruction can help develop their deeper critical thinking about what is really happening when they engage with patients and colleagues through social media platforms.

Despite these very real, often-unexamined issues, the virtual environment generated through social media affords unique benefits for communication. Common practices of content reiteration and remixing (combining content and even techniques of different media types) connect participants in unique ways while producing new hybrid forms of knowledge. Virtual tagging practices (tags generated dynamically to sort, group, and display items) continually reconfigure knowledge while remixing past and present.[31] The phenomenon of our "traces" or digital footprints in virtual environments (photos, Web pages, posts, even our patterns of clicks and selections, etc.) creates resources that can be harvested in useful ways. Instead of promoting anxiety and control-seeking, we educators might help students think more in terms of distributed agency, emerging human–nonhuman interactions, and surprising new forms of practice.[32]

Issues for Further Research

More studies are needed—a common refrain among medical researchers publishing about social media. We need robust, comparative accounts of how physicians and students in different clinical contexts actually use social media in their everyday practice. Nuanced empirical examinations in situ can trace practitioners' dilemmas and how they

negotiate these, showing the conflicting norms and obligations at play. How do professional identities shift and adapt through social media? What identities are constructed online? What forms of professional–patient communication are evolving online?

We also need studies providing evidence about the effectiveness of using social media to engage the public, provide service, and disseminate useful information. How can physicians communicate better with the public online? What innovative uses of evolving social media can improve outreach, involve patients and families more meaningfully in health decisions, promote public debate about health, and disseminate up-to-date information? Cross-professional studies in the public service sector can be useful here, as social media use is generating broad experiments in policing, nursing, pharmacy, teaching, and social care.[12,33,34] Research also needs to examine not just the behavior of professionals but also their online interaction with the public.

This sort of research could help identify new guidelines for and issues regarding professionalism in social media that avoid the ideological closure or simple restricting of e-professionalism. Further, this approach challenges the prevailing focus on how single individual practitioners use social media tools for certain predetermined objectives. Instead, we need to acknowledge how clinicians are continually configuring and being reconfigured in their professionalism as they engage online. Studies need to track these dynamics against the changing capacities and applications of technology and its changing norms of use. Such studies turn from preoccupation with behaviors of the individual medical professional to professionals-in-relation: with patients and families, with colleagues from one's own profession and other allied occupations, with stakeholders and advocates, and with the social media tools themselves.

In Sum

The growing literature about online medical professionalism is highlighting important problems. Some of it, however, may be reinforcing old discourses of professionalism as containment and control. I suggest that we physicians look more deeply at what constitutes professionalism. Regulations and in-

struction in online behavior can help address some immediate issues but may not develop students' capacity to think critically about their engagements in digital worlds. Nor can such restrictive, didactic approaches to professionalism help students to navigate the larger issues at stake in their practice: central conflicts between profession and professionalism, and contradictory demands among stakeholders. New social media are continually appearing, often in response to what users do, with profound effects on both social norms and the meaning of professionalism. These media need broad critical examination by educators as well as students to appreciate how they influence interactions, relationship structures, the meaning of privacy, and the value of certain types and bodies of knowledge.

The approach I advocate does not rush to govern "bad" social media practices but, rather, looks more closely—and more critically—at its current and future implications for practice beyond the simplistic, dualistic good/evil framing. We need more empirical research examining professionals' and students' everyday experiences and strategies in working through dilemmas, as well as the implications of these strategies and experiences. We need to foster new understandings of how using social media affects professional boundary issues, online identities, relations with patients and other stakeholders, and professional learning. As we study these questions, we are likely both to witness new guidelines governing professionalism and to develop new understandings of the notion of professionalism. Given the widespread shift to treat professionalism as a pluralistic range of practices rather than as a singular set of virtues or state of being, we might focus on tracing the new forms of professionalism that are emerging through various online experiments. The most important question may not be how to protect professionals online but, rather, how social media can open new debates about medical professionalism for better patient care and healthier societies.

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Transforming Educational Accountability in Medical Ethics and Humanities Education Toward Professionalism

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Abstract

Effectively developing professionalism requires a programmatic view on how medical ethics and humanities should be incorporated into an educational continuum that begins in premedical studies, stretches across medical school and residency, and is sustained throughout one's practice. The Project to Rebalance and Integrate Medical Education National Conference on Medical Ethics and Humanities in Medical Education (May 2012) invited representatives from the three major medical education and accreditation organizations to engage with an expert panel of nationally known medical educators in ethics, history, literature, and the visual arts. This article, based on the views of these representatives and their respondents, offers a future-tense account of how professionalism can be incorporated into medical education.

The themes that are emphasized herein include the need to respond to four issues. The first theme highlights how ethics and humanities can provide a response to the dissonance that occurs in current health care delivery. The second theme focuses on how to facilitate preprofessional readiness for applicants through reform of the medical school admission process. The third theme emphasizes the importance of integrating ethics and humanities into the medical school administrative structure. The fourth theme underscores how outcomes-based assessment should reflect developmental milestones for professional attributes and conduct. The participants emphasized that ethics and humanities-based knowledge, skills, and conduct that promote professionalism should be taught with accountability, flexibility, and the premise that all these traits are essential to the formation of a modern professional physician.

Since 1998, scholarly and educational accreditation organizations have stressed the fundamental importance of professionalism in medical education.[1-3] Promoting professional development is central to the mission of medical schools and residency programs, as reflected in its promotion and evaluation by the Association of American Medical Colleges (AAMC), the Liaison Committee on Medical Education (LCME), and the Accreditation Council for Graduate Medical Education (ACGME). The Project to Rebalance and Integrate Medical Education (PRIME), formed in 2009, has forged a coalition of medical educators, administrators, and accreditors from these three organizations to promote ongoing discussion on medical education reform. Since its inception, PRIME has stimulated collaboration and elucidated the role of medical ethics and humanities in professionalism formation.[4-7]

We will refer to PRIME's prior works on medical education activities that fit into the rubric of "medical ethics and humanities." We have previously articulated a framework of four broad areas of knowledge and skills that we believe are an integral part of medical education at all levels: argument-based reasoning in medical ethics (including the contributions of the disciplines of law, anthropology, and sociology); narrative-based reasoning in literature; creative reasoning in the fine arts; and historical reasoning in learning.[4,5] These knowledge and skills cultivate critical thinking skills required in health care practice. Mentors complement this process by modeling professionalism in patient-centered care.

The open-invitation PRIME National Conference on Medical Ethics and Humanities in Medical Education, "Reforming Ethics & Humanities Teaching in Medical Education: Fulfilling the Future Accreditation Goals on Professionalism," was held May 10 and 11, 2012, in Louisville, Kentucky. Discussions on how—and whether—to frame outcomes-based education in medical ethics and humanities (particularly regarding the promotion of professionalism) was a major theme, especially given the difficulty of assessing such outcomes in varied contexts. Our proposed solution is that professionalism must be taught and assessed using an outcome-based framework. The outcomes of teaching professionalism must extend to behavioral change (i.e., learners translating their knowledge and skills into behavioral change) and results (e.g., enhanced patient care, interprofessional conduct, reduced errors).[8] To make these points, we must first address "Why" and "Why now?"

Formation of the medical professional, as noted in our prior work, requires three essential commitments of each physician. First, establish competence by cohering to rigorous and accountable evidence-based medicine.[6,7] Second, use this knowledge and skill set "to protect and promote the patient's health-related interests as the physician's primary concern and motivation, keeping self-interest systematically secondary."[6] Third,

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adhere to and entrust the knowledge, skills, and virtues of medical care to future generations of "physicians, patients and society as a public trust," eschewing self-interest.[6]

Since 1999, there has been a shift in the professionalism discussion regarding medical education. Constructs have been advanced that attempt to translate professionalism formation into outcomes-based end points.[9,10] These efforts use a virtue-based approach coupled with discrete behavioral expectations in patient-centered care.[2,11] This is a response to increasing pressures for accountability by accreditation organizations and others with the need to demonstrate that funding provided to education results in quality physicians.[2,3] All U.S. medical schools and residencies must satisfy these accreditation requirements. We recognize the competencies-based account of professionalism, and also reaffirm the knowledge, benefit, and trust commitments noted previously on medical professionalism, as these approaches are not contradictory. The PRIME national conference stressed the need for open-mindedness in educational processes regarding professionalism. There is no singular way to teach or assess the learner.[12] Instead, diversity in pedagogical goals, processes, and outcomes is expected and desired.

The Foundation of Reform

Prominent aspects of the financing and delivery of health care in the United States create dissonance with the moral precepts taught to trainees during professional training. The current deficiencies of the U.S. system also illuminate severe challenges for physicians to live up to our ethical obligations as health care professionals because the current system often fails to attain "social justice" in health care.[13]

The United States suffers from inequities in health care outcomes by region, gender, ethnicity, socioeconomic status, and insurance status. As the United States implements the Affordable Care Act (ACA), it appears that the percentage of uninsured Americans is falling, but the most recent figures from the Kaiser Family Foundation show that more than 47 million people in the United States were uninsured in 2012.[14,15] The United

States is near the bottom of industrialized nations in life expectancy, with extremely high infant mortality and adult obesity rates (resulting in increased chronic disease prevalence).[16,17]

With these poor outcomes, the United States far outspends other nations, using 17.6% of its gross domestic product on health care.[18] The United States paradoxically designates less to spend on nonmedical programs, such as services for the hungry and desperately impoverished, which could mitigate some of the negative foundational health factors.[19] The U.S. health care system is at a tipping point of unsustainability. With the ACA's implementation, this is a moment for reflecting on accountability, not just in fiscal terms, but also with respect to the moral enterprise that is core to the practice of medicine. Each physician who enters into the social contract of caring for patients must contend with the system's inadequacies. Each physician must have the requisite professionalism to identify how these external factors threaten their ability to deliver humane and competent medical care and act to address the deficiencies.

Communication skills are a major aspect of medical professionalism and how the public perceives physicians. Regrettably, only two-thirds of respondents in public polling expressed that "physicians have a good bedside manner," with one-third dissatisfied with this essential humanistic skill. In contrast, the same study showed that 85% of the public believe that physicians have "good" or "excellent" "medical knowledge."[20]

One well-studied variable in professional development is the influence of the "hidden curriculum" embedded within medical learners' environments.[21] At the bedside, the requirement to follow institutional and provider team norms can lead ethical students and residents to engage in unprofessional behavior during medical training (e.g., falsifying medical records because of a shortage of time) that could be carried over into the physician's career, ultimately resulting in disciplinary action.[22] Another set of well-studied challenges to professionalism are potential conflicts of interest created by industry that can affect physician decision making.[23]

This transformative moment in U.S. health care requires the profession to assert the need for professionalism and

to assess the ethical and humanistic foundation provided throughout the educational continuum of medicine. Professionalism begins in the premedical environment, spans across medical school, continues throughout residency and fellowship training, and extends through continuing medical education, thereby preparing, educating, and sustaining practice patterns necessary for decades of clinical practice devoted to the care of patients.

The Premedical Years

Three domains shape recent changes in premedical curricula: academic readiness, "preprofessional" readiness, and diversity—leading into a holistic review during the admissions process. The Medical College Admission Test has been revised to include not only the natural and life sciences but also core principles in the social and behavioral sciences, and critical analysis and reasoning skills.[24] These welcome changes encourage premedical learners to appreciate exposure to philosophy, anthropology, sociology, and psychology as valuable preparation toward medical education, including the groundwork of critical thinking skill building.

Additionally, premedical students will be evaluated for "preprofessional" personal competencies by premed advisors, those writing letters of recommendation, and medical school admission committees. These competencies are based on knowledge, skills, and experiences from the social, ethical, and interpersonal domains that serve as a foundation for further maturation in the medical education process. The nine "preprofessional" competencies are service orientation, social and interpersonal skills, cultural competence, teamwork, integrity and ethics, reliability and dependability, resilience and adaptability, capacity for improvement, and oral communication.[25]

PRIME conference faculty concurred that this paradigm shift in the medical school admissions process requires screening that reviews applicants in a way that transcends factual knowledge testing. The experiences of the student, and the letters of recommendation that reflect these experiences and attributes, should become increasingly important. The emphasis should shift

from applicants who simply score best on knowledge-based tests to those who exemplify professionalism. In turn, medical ethics and humanities should be transformed from "elective" prerequisites for admission to essential components in the foundation necessary to become a physician. This background will better enable the physician to reflect on subtleties of the physician–patient relationship and to be prepared for the ethical dilemmas in medical practice. Ethics, literature, art, and history provide means to foster this reflective capacity.[4,5]

The Medical School Years

Matriculation into medical school marks a transition where the educational outcomes are assessed as students develop skills and acquire knowledge focusing on the patient. Rather than prescribing credit hours in required topics, the LCME is less prescriptive regarding requirements of content and expected outcomes. The number of hours devoted to particular subjects, space, faculty numbers, and instructional formats are not rigidly specified. Each medical school must ascertain how to best use its resources to deliver the requisite content based on its defined mission and educational program objectives. Content acquisition is assessed nationally by the United States Medical Licensing Examination and by internal assessments.

The LCME accreditation standards in place now state that "a medical education program must include behavioral and socioeconomic subjects.… [Including] medical humanities [and] medical ethics" and "must include instruction in medical ethics and human values and require its medical students to exhibit scrupulous ethical principles" (ED 10 and 23).[26] To evaluate these topics, the LCME requests a basic listing of the number of sessions, a review of how student learning is assessed, and student evaluations of their education in these areas. Medical schools must also describe how breaches of ethical conduct are handled. Despite, or because of, these requisite overarching goals for ethics and humanities, about 1 in 11 students believe their course work is excessive in ethical decision making, and 1 in 6 believe their instruction in "professionalism" is excessive.[27] This may be because students do not fully understand the relevance of the information in the context of patient care.

The necessary end point of "appropriate" content in ethics and humanities should be the students' successful attainment of knowledge and skills that facilitate their formation as medical professionals. The AAMC Medical School Graduation Questionnaires allow the LCME to follow up on outliers (those where a significant number of students identify "inadequate" coverage of a topic). The evaluation of content coverage is qualitative, not quantitative, and each medical school must define how ethics and humanities contribute to their educational objectives and competencies in professionalism.

The consensus among PRIME faculty was that curricula in ethics and humanities geared toward fostering professionalism should be structured upon defined competencies and articulated outcomes that are linked to longitudinally integrated content and assessment. The LCME expects that educational program objectives should "be stated in outcome-based terms that allow assessment of student progress in developing the competencies that the profession and the public expect of a physician" (ED 1A).[26]

Meaningful inclusion of ethics and humanities in the curriculum may be more likely if these subjects have an "organizational home," such as a department or center. In 2011, only 28 of 125 medical schools had ethics and/or humanities as a formal department or center or had an associate dean in ethics and/or humanities, according to a survey sent to all deans of the LCME-accredited medical schools (which had a 100% response rate).[28] The explicit inclusion of ethics and humanities as foundational to medical education competencies clearly calls for the existence of a formal curriculum in ethics and humanities that ideally is integrated in, and throughout, the medical school curriculum. Its presence should be continuous, with elements throughout the preclinical and clinical experiences that build progressively toward students achieving the desired competencies. Challenges include defining terms, acknowledging current pedagogical organization, and linking teaching and assessment to comprehensive prespecified outcomes. Each school must define the content to be included under the category "medical humanities," and link this content to the school's competencies and mission. Governance of the curriculum and

the relationship to the school's power structure is of particular importance in considering the ability to include these subject areas, as medical ethics and humanities faculty may or may not participate in the curriculum governance process.

Many medical schools do not have properly trained faculty in ethics and humanities to ensure that proper expertise is available for pedagogy and in curricular planning related to professionalism, making the threats of the hidden curriculum more tangible. Educational programs in ethics and the humanities need to be taught by experts comparable to those faculty teaching more traditional disciplines, lest these important topics suffer not because of content but because of poor execution. Medical school faculty members need to be explicitly aware of how ethics and the humanities contribute to the objectives and competencies for physicians-in-training. Educators without such training may be higher in the power structure with conferred authority over professionalism education, but could be at a disadvantage in advocating for curricular content and time when compared with faculty members with this training or compared with trained educators in nonprofessionalism content areas. Ethics and humanities faculty members, regardless of background, need to ensure that their faculty peers and students understand their contributions to professionalism formation. Schools should endeavor to broaden faculty development and resources in these critical domains to ensure a sustainable and high-quality effort in ethics and medical humanities.

For medical ethics and humanities education to be salient in professionalism pedagogy, educators need to evaluate proactively how they contribute to professional outcomes. These outcomes may be qualitative or quantitative, but should be articulated by the school, and then evaluated for the success or failure of the teaching effort. Objectives of teaching must be directed toward instilling the desired values and behaviors into each student. The integration of medical ethics and humanities should be with "a distinct practical purpose in view"—the beneficial care of the patient.[29] It is also important to acknowledge that the humanities do not lend themselves to the same quantitative

assessment of the physical sciences. Other, more relevant means of assessing outcomes are needed. The teaching should be based in clearly articulated goals, even if not toward quantitative outcomes.

The Residency Years

Residency training is associated with a change in the focus and outcomes of medical education. The ACGME aims for each learner to progress on a pathway from novice to mastery in the requisite knowledge, attitudes, skills, and behaviors to care for patients. Residency is also a period of professional development when lifetime habits of mind and practice are consolidated and thus is especially ripe for instruction in professionalism.[30]

One of the outputs of discussions at the PRIME conference was that this model requires a proactive stand on assessment. The ACGME (and the National Board of Medical Specialties) strives for resident learners to master the content and behavior outlined in the general competencies. The ACGME's warrant is grounded in the social contract to ensure that residency programs produce physicians who exhibit the values and virtues of professionalism. This warrant also aims to ensure the safety of medical encounters that are conducted with humanistic caring and self-effacement (also called altruism). Residency educators, then, must be advocates for our residents *and* our patients, while being excellent role models whom residents can emulate.

This effort is challenged by the realities of residency training, which may include a training environment in which problematic or even disruptive behavior is tolerated; the specific challenges encountered by trainees, such as stress and sleep deprivation; and insufficiencies related to faculty, such as training, commitment, numbers, support, and reward. For example, evidence indicates that even when faculty are supervising trainees' interactions with patients, they don't take advantage of the available opportunities to teach about ethics, humanities, and professionalism.[31,32] Finally, medical ethics and humanities educators must recognize that they are competing with others for precious time in the curriculum, in the context of a shrinking workweek due to duty hours restrictions. Securing and maintaining time with learners will require ongoing effort and vigilance.

The focus of ACGME accreditation has shifted recently, with emphases on educational innovation and improvement, improved attention to educational outcomes, greater efficiency in accreditation, and enhanced communication and collaboration with key internal and external stakeholders. The ACGME's Next Accreditation System intends to shift the goals to outcomes-based learning, thereby giving programs latitude to design ways to meet these outcomes.[33] This system allows good programs to innovate and continuously improve, while assisting improvement of poor programs.

This enhanced flexibility in accreditation allows for a more appropriate review of programs based on specific specialty needs, with a more meaningful and more manageable review of programs. Implicit in this accreditation change is the need for faculty development, including program directors and residency review committees, to engage residents in assessment of milestones. Overall, the burden of accreditation should be substantially reduced.

The ACGME is setting the stage for semiautonomous administration of resident maturation, giving each program the opportunity to transform its learning environment, along with each teacher and learner. In the competency of professionalism, residents must demonstrate the inculcation of virtues and ethical principles that will support provision of care consistent with the highest ethical and professional standards. Professionalism is a subset of all milestones that are evaluated in all of the competencies. Importantly, given recent lapses in some residency programs regarding testing fraud, the ACGME has a requisite expectation that professionalism be part of all resident *and faculty* member skill and behavior sets.[34,35] These virtues and principles require educators to be engaged in meaningful ongoing relationships with trainees so that they can role model, observe, challenge, share, process, give feedback to, evaluate, and guide each resident on a moral journey of personal development.

It is important to note that the PRIME conference did not extend its efforts to the next opportunities for professionalism training in fellowship programs, and the continuity of professionalism in ongoing clinical care. The Academy for

Professionalism in Health Care (APHC), founded at the PRIME conference, will examine the postresidency aspects of professionalism and work with relevant accreditation organizations (the ACGME and its review committees, and the Accreditation Council for Continuing Medical Education) to examine how medical ethics and humanities education can promote professionalism at these career stages.[36]

Discussion

The PRIME conference emphasized that all educators, including those in medical ethics and humanities, are held accountable to the educational standards of the LCME and ACGME. Educators from each school and residency program must tailor their curricular goals and objectives toward meeting the ACGME's general competencies, of which professionalism plays a pivotal and pervasive role. Faculty assets and institutional culture will constrain and circumscribe these goals and objectives. These factors necessitate that each program have substantial latitude to use varied approaches, methods, and outcomes for assessment. From this overarching message, two major areas of focus resulted from the PRIME conference.

First, medical ethics and humanities education is essential to the formation of professionalism by enhancing ethical reflection and critical thinking skills. Moral introspection and analytic skills enhance discernment of the morally problematic aspects of health care and reinforce the altruistic foundation of medicine. These efforts should result in developing physician activism to address our health care system's flaws as well as to recognize the challenges to their own professional selves. The critical nature of developing introspection within each physician is underscored by recent evidence from Tilburt and colleagues[37]: Of more than 2,500 physicians surveyed about "who bears major responsibility for health care costs," a majority of physicians chose trial lawyers, hospitals, insurance companies, and patients—more than they chose physicians themselves. These attitudes emphasize how ethics and social justice require physicians to consider whether they can abrogate their responsibility for the system.[13]

Enhanced professionalism education may facilitate learners' recognition of

health care injustice and the perils of self-interest, aiding in their combating quiescence of health inequity and having them reject nonaltruistic motives. Future professionalism pedagogical research should demonstrate how medical learners use their moral reflection skills to overcome injustice and unprofessional behavior and promote the ideals of just care, cultural competence, and diversity. These educational efforts should demonstrate that the values of altruism, fairness, and tolerance endure through the challenges of the hidden curriculum—such that our professional physicians can thereby better serve society as change agents.

Ethics and humanities education has obvious ties to the LCME and ACGME competencies generally, and to professionalism specifically.[6] Including ethics and humanities in accreditation encourages accountability of the specific area of knowledge, attitudes, skills, and behaviors in professionalism formation. Medical learners benefit through the actualization of professionalism in the physician–patient relationship. LCME and ACGME goals not only tolerate diversity of methodology but also encourage and promote it. Diversity of pedagogy ranges from traditional in-person didactic, small-group, work rounds, and one-on-one interactions and role modeling, to electronic aspects of education using Web streaming, podcasting, and videoconferencing. The PRIME conference emphasized that an open approach to pedagogy and an open-source approach to storing and sharing medical education materials would benefit all programs. In this regard, PRIME and the APHC entered into a strategic alliance with the AAMC MedEdPORTAL program (MedEdPORTAL.org) to help build a database of educational material in professionalism, ethics, and humanities that is peer reviewed, cross-linked, and an open source for collaboration.[38] APHC members are actively engaged in ongoing program development in medical ethics and humanities education to foster professionalism leading to the formation of physicians who can think and practice creatively and humanely.

Second, educational efforts toward professionalism require critical appraisal of previous efforts, assessing omissions, errors, and flawed framing. Some ethics and humanities educators may fear "standardized" content, thereby ossifying the evolution of a diverse curriculum. PRIME conference attendees agreed that such rigidity would be inappropriate and advocated instead for diverse perspectives and approaches. Lockstep, concrete pedagogy would stymie innovation and be antithetical to scholarship and academic freedom. Such rigidity would also fail to meet site-specific contexts and standards regarding professionalism.

Standardization contradicts the stand of the PRIME faculty and the accreditation organizations on how medical education can best evolve. We prefer accountability, which can best be achieved when educators have a palette of goals, objectives, methods, and assessment means drawn from many disciplines and programs, so that all programs can decide what to do with the resources they have for the culture they wish to promote. Taking a "core content" approach with wide variation in delivery allows for evolution of medical education while also maintaining those aspects of professionalism most salient to future physicians.

Some Challenges

The largest challenge for some educators may be moving beyond the intrinsic value of the educational content to the requisite setting of goals, objectives, and evaluation. Outcomes-based education requires translation from disciplinary grounding to assessable impact (directly or indirectly) on patient care. Professionalism allows us to care for patients in ways that actualize our knowledge of medical ethics and humanities beyond a theoretical construct.

We assert that ethics and humanities have a special role to play in helping trainees to become medical professionals and in sustaining the professionalism of practicing physicians. In this context, ethics and humanities are instrumental—and there is a requisite need to determine whether the intended impact has been made on the learner. Educational evaluation of ethics and humanities is something we can no longer ignore. Doing so imperils the impact of educational reform and risks complete political marginalization within medical schools and training programs.

Concluding Remarks

The prior two PRIME workshops (in 2010 and 2011) and the 2012 PRIME national conference concluded that ethics and humanities are a fundamental component for the development of professionalism in the medical learner.[5,6] The development of professionalism is based on the knowledge, attitudes, skills (including critical thinking skills), and behaviors that are acquired from a foundation in medical ethics and humanities education. Educators involved in the broad spectrum of medical ethics and humanities education must work together to create a vision of their essential role in the development of the medical professional. It is agreed that medical ethics and humanities educators need to reject notions of reductionism that some fear might accompany educational evaluation. At the same time, educators must embrace imaginative, diverse thinking on how ethics and humanities can and should contribute to medical education toward professionalism. This will be essential if our learners are to become the medical professionals that patients and society deserve. Structural changes in medicine mean that educators cannot take for granted that professionalism will survive reform. Ultimately, educators will be held accountable for trainees' attainment of the ACGME's general competencies, including professionalism.

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The Essential Role of Medical Ethics Education in Achieving Professionalism: The Romanell Report

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Abstract

This article—the Romanell Report—offers an analysis of the current state of medical ethics education in the United States, focusing in particular on its essential role in cultivating professionalism among medical learners. Education in ethics has become an integral part of medical education and training over the past three decades and has received particular attention in recent years because of the increasing emphasis placed on professional formation by accrediting bodies such as the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education. Yet, despite the development of standards, milestones, and competencies related to professionalism, there is no consensus about the specific goals of medical ethics education, the essential knowledge and skills expected of learners, the best pedagogical methods and processes for implementation, and optimal strategies for assessment. Moreover, the quality, extent, and focus of medical ethics instruction vary, particularly at the graduate medical education level. Although variation in methods of instruction and assessment may be appropriate, ultimately medical ethics education must address the overarching articulated expectations of the major accrediting organizations. With the aim of aiding medical ethics educators in meeting these expectations, the Romanell Report describes current practices in ethics education and offers guidance in several areas: educational goals and objectives, teaching methods, assessment strategies, and other challenges and opportunities (including course structure and faculty development). The report concludes by proposing an agenda for future research.

In 1985, the landmark article "Basic Curricular Goals in Medical Ethics," known as the DeCamp Report, argued that basic instruction in medical ethics should be a requirement in all U.S. medical schools.[1] That same year, the Liaison Committee on Medical Education (LCME) introduced standards stipulating that in U.S. medical schools "ethical, behavioral, and socioeconomic subjects pertinent to medicine must be included in the curriculum and that material on medical ethics and human values should be presented."[2] More recently, medical educators and accrediting organizations have expanded the scope of ethics education guidelines, manifested in part by requirements that learners at all levels receive instruction addressing professional formation to prepare them for a lifelong commitment to professionalism in patient care, education, and research.[3] A physician's ability and willingness to act in accordance with accepted moral norms and values is one key component of professional behavior; as a result, educational objectives relating to ethics are now often incorporated into broader goals for professionalism education.

Despite broad consensus on the importance of teaching medical ethics and professionalism, there is no consensus about the specific goals of medical ethics education for future physicians, the essential knowledge and skills learners should acquire, the best methodologies and processes for instruction, and the optimal strategies for assessment.[4–8] Moreover, the quality and extent of instruction, particularly at the graduate medical education (GME) level, varies within and across institutions and residency training programs.[9–11] Although such variation may be appropriate in light of differences in educational contexts, medical ethics education efforts must ultimately address the overarching expectations articulated by accrediting organizations. Variation raises concerns about whether all approaches succeed in meeting basic educational objectives, which leads to the question, "Which approaches to medical ethics education are most effective?"

This article, the Romanell Report, is a product of the Project to Rebalance and Integrate Medical Education (PRIME), funded by the Patrick and Edna Romanell Fund for Bioethics Pedagogy. PRIME was a national working group that focused on medical ethics and humanities education as they relate to professionalism education in medical school and residency training.[12,13] PRIME led to the founding of the Academy for Professionalism in Health Care as an organization devoted to professionalism education.[14]

As members of PRIME with a particular interest in medical ethics education, we address in this report the essential role of such education in cultivating professionalism among medical learners. We previously described medical professionalism as (1) becoming scientifically and clinically competent; (2) using clinical knowledge and skills primarily for the protection and promotion

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of the patient's health-related interests, keeping self-interest systematically secondary; and (3) sustaining medicine as a public trust, rather than as a guild primarily concerned with protecting the economic, political, and social power of its members.[13]

We take our working definition of "medical ethics" from a prominent textbook on clinical ethics: "Clinical ethics concerns both the ethical features that are present in every clinical encounter and the ethical problems that occasionally occur in those encounters."[15] In addition, we consider medical ethics to include attention to determining what ought to be done when problems or values conflicts are present: that is, determining the right course of action or a morally acceptable choice from among the available options.

We consider it self-evident that there is a close relationship between medical ethics and professionalism and that the extensive body of scholarship on medical ethics informs how we think about professionalism. However, a thorough analysis of this relationship is beyond the scope of this article. We do not address the important role of humanities education in the pursuit of professional formation in this report; we plan to focus on that in future work. Additionally, although our focus in this article is on medical ethics education during medical school and residency training, we acknowledge that the educational continuum extends on either side of this focus. We believe that medical ethics and professionalism should also be made a priority during premedical studies and reinforced post residency through continuing medical education (CME).

In this report, with the aim of aiding medical ethics educators in meeting the articulated expectations of accrediting organizations, we address the following aspects of medical ethics education in medical schools and residency programs: goals and objectives, teaching methods, assessment strategies, and additional challenges and opportunities. We conclude by recommending next steps and areas for future study.

Goals and Objectives

Although most educators agree that the central goal of medical ethics education is to promote excellence in patient care,

there are diverse views about how best to achieve this aim.[4] Whereas some educators emphasize the importance of developing future physicians' character, others hold that shaping their behavior is a more appropriate focus. Still others believe that ethics and professionalism cannot be taught; rather, virtuous individuals must be selected through the medical school admission process. The debate among proponents of these schools of thought is unlikely to be resolved in the near future.

Although medical schools should seek to select students with the "right" character and attitudes, those qualities are difficult to assess accurately. Further, effecting character change in the limited time available for medical ethics and professionalism education seems challenging at best. The practical challenges of shaping and evaluating character traits logically lead to the alternative: cultivating *behavior* that exemplifies ethical and professional virtues. The foundation of this approach is to provide trainees with conceptual tools for seeing, preventing, analyzing, and resolving the ethical dilemmas encountered in clinical medicine. Although an argument can be made that this pragmatic approach is not ideal, it is a workable compromise that may be the best available option given existing constraints.

This focus on behavioral goals is supported by the major accrediting bodies for U.S. medical schools and residency programs, which have established behavior-based standards and competencies that learners must achieve during training. For example, LCME standard ED-23 states: "A medical education program must include instruction in medical ethics and human values and require its medical students to exhibit scrupulous ethical principles in caring for patients and in relating to patients' families and to others involved in patient care."[16] The LCME specifies that students' behavior must be observed and assessed to ensure that it is in line with accepted ethical guidelines.

Similarly, the Accreditation Council for Graduate Medical Education (ACGME) has defined six core competencies[17] and has called for the development of milestones that establish benchmarks for the behaviors that physicians

completing U.S. residency programs must demonstrate for each competency. One of the six core competencies specifically focuses on professionalism, stating, "Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles." Residents are expected to show compassion and respect for others, put patients' needs above their own, respect patients' autonomy, act accountably, and demonstrate sensitivity to patients from diverse backgrounds. The ACGME has left it to individual specialties to define the milestones that compose this core competency. As an example, the professionalism milestones identified by the American Board of Internal Medicine are presented in Table 1. It should be noted that all six of the ACGME core competencies involve various aspects of professionalism, explicitly or implicitly.

With respect to the continuum of medical learning, there is interest in extending the focus on competencies and milestones beyond GME. Some educators suggest integrating them into undergraduate medical education (UME) as well as addressing them as part of CME and maintenance of certification.[18]

In addition, attention has been directed at linking milestones to instances of actual clinical practice by defining entrustable professional activities (EPAs) and using them as a basis for assessing learner performance.[19] To successfully and independently perform one of these core clinical activities, learners must not only demonstrate the requisite knowledge, attitudes, and skills but also seamlessly integrate competencies, subcompetencies, and milestones. Some educators[18] have argued for tailoring EPAs to the learner's developmental level, which could serve to further integrate the learning continuum.

EPAs, milestones, and competencies define where learners are expected to be by the end of their training, but they do not specify the detailed objectives that educators should use to lead them there. Among ethics educators, there is no consensus on a set of specific objectives for medical ethics education, although several lists of key skills and topics have been put forward.[20–22] Our attempt to synthesize current thought on a minimum set of objectives for medical ethics education is presented

Table 1

Professionalism Milestones for Residents in ACGME-Accredited Internal Medicine Residency Programs[a]

Professionalism subcompetency	Aspirational milestone
Has professional and respectful interactions with patients, caregivers, and members of the interprofessional team (e.g. peers, consultants, nursing, ancillary professionals and support personnel). (PROF1)	• Role models compassion, empathy, and respect for patients and caregivers • Role models appropriate anticipation and advocacy for patient and caregiver needs • Fosters collegiality that promotes a high-functioning interprofessional team • Teaches others regarding maintaining patient privacy and respecting patient autonomy
Accepts responsibility and follows through on tasks. (PROF2)	• Role models prioritizing multiple competing demands in order to complete tasks and responsibilities in a timely and effective manner • Assists others to improve their ability to prioritize multiple, competing tasks
Responds to each patient's unique characteristics and needs. (PROF3)	• Role models professional interactions to negotiate differences related to a patient's unique characteristics or needs • Role models consistent respect for patient's unique characteristics and needs
Exhibits integrity and ethical behavior in professional conduct. (PROF4)	• Assists others in adhering to ethical principles and behaviors including integrity, honesty, and professional responsibility • Role models integrity, honesty, accountability, and professional conduct in all aspects of professional life • Regularly reflects on personal professional conduct

Abbreviations: ACGME indicates Accreditation Council for Graduate Medical Education; PROF, professionalism.
[a]*Source:* Accreditation Council for Graduate Medical Education, American Board of Internal Medicine. Internal Medicine Milestone Project.[77]

in List 1. These objectives apply to both medical students and residents, with greater proficiency expected of higher-level trainees. This list was developed collaboratively by our group of experienced educators and draws on relevant empirical studies and other published literature.[4,6,9,20,21,23] It is important to emphasize that this list represents what we consider to be the basic requirements for medical ethics education. We acknowledge that other objectives to promote professionalism in learners (i.e., objectives incorporating other specific skills and topics) could be added to this list.

For comparison, we have summarized the objectives for medical ethics education presented in the 1985 DeCamp Report[1] in List 2. The objectives proposed in this report (List 1) differ from the earlier objectives in several ways. First, our objectives are more comprehensive, which may reflect an increased emphasis on ethics and professionalism in medical training and therefore an expectation that more curricular time will be devoted to these topics. It may also reflect the

broadening scope of the still-developing field of bioethics. A second difference between the objectives offered in the DeCamp and Romanell Reports is our inclusion of items that take into account the context in which medicine is practiced, particularly issues of access to health care and cultural competence. The inclusion of these items mirrors recent social trends—expanding awareness of socioeconomic inequalities, emphasizing the social determinants of health, and increasingly respecting and valuing diversity. Third, our expansion of ethical considerations beyond the patient–physician dyad to interprofessional interaction and self-care should be noted. An improved understanding of the important role of effective teams in preventing medical errors and in offering patients excellent care can explain our addition of an item on working within the medical team. The attention to self-care reflects a developing awareness that experiencing a loss of meaning in clinical practice and inadequate work–life balance can lead to waning commitment, dissatisfaction, and burnout,[24] and these in turn can be associated with lapses

in professionalism.[25,26] Fourth, the DeCamp Report objectives emphasize moral reasoning and knowledge to be acquired in specific content areas, but devote less attention to specific skills to be developed. Our inclusion of more skills-based items in the Romanell Report objectives reflects accrediting agencies' move toward evaluation of learners' actual performance in clinical encounters and their achievement of corresponding milestones.

In addition to these differences in learning objectives, the Romanell Report devotes attention to several areas not addressed by the DeCamp Report: methods of teaching, assessment strategies, and additional challenges and opportunities. We now turn our attention to these issues.

Teaching Methods

There is no single, best pedagogical approach for teaching medical ethics and professionalism. Learning styles and institutional resources vary, so teaching methods need to be flexible and varied to reflect this diversity. For example, to address the ACGME professionalism subcompetency "sensitivity and responsiveness to a diverse patient population,"[17] an educator could deliver a conventional didactic lecture, present clinical cases, or show a "trigger tape" intended to inspire discussion and debate.[27] Similarly, articles that illuminate issues of diversity by presenting patient perspectives[28,29] or that address the evolution of different "worldviews" on health and healing could be assigned and discussed.[30] Another pedagogical technique is to invite learners to write reflective narratives about cases they have been involved in that have raised ethics issues.[31,32] Whenever possible, medical ethics and professionalism instruction should involve collaboration among faculty from different disciplines to reinforce the team approach required in clinical practice. In recent years, multidisciplinary contributions to professionalism teaching have expanded beyond the traditional fields of philosophy, history, literature, law, and social sciences to include applied methods from the arts such as improvisational theater exercises,[33] comics drawing,[34] creative writing practices,[35] and fine art study.[36–38]

List 1
Proposed Objectives for Medical Ethics Education

Upon completion of medical school or a residency training program, learners will, with an appropriate level of proficiency:

- Demonstrate an understanding of the concept of the physician as fiduciary and the historical development of medicine as a profession
- Recognize ethical issues that may arise in the course of patient care
- Utilize relevant ethics statements from professional associations to guide clinical ethical judgment and decision making
- Think critically and systematically through ethical problems using bioethical principles and other tools of ethical analysis
- Provide a reasoned account of professionally responsible management of ethical problems and act in accordance with those judgments
- Articulate ethical reasoning to others coherently and respectfully

Upon completion of medical school or a residency training program, learners will, with an appropriate level of proficiency, manage ethical challenges in a professional manner in the following areas:

- Protection of patient privacy and confidentiality
- Disclosure of information to patients, including medical errors and the delivery of bad news
- Assessment of patient decision-making capacity and issues related to surrogate decision making
- Shared decision making, including informed consent and informed refusal of medical interventions by patients
- Care at the end of life, including patient advance directives, withholding and withdrawing life-sustaining interventions, care for the dying, and determination of death
- Maternal–fetal medicine, including reproductive technologies and termination of pregnancy
- Pediatric and neonatal medicine
- Access to health care, including health care disparities, the health care system, and the allocation of scarce resources
- Cross-cultural communication, including cultural competency and humility
- Role of the health care professional's personal values in the clinical encounter, including the extent and limits of the right of conscience
- Conflicts of interest and of obligation in education, clinical practice, and research
- Research with human subjects, including institutional review boards
- Work within the medical team, including interprofessional interactions
- Concerns about colleagues, including impairment, incompetence, and mistakes
- Medical trainee issues, including disclosure of student status, the tension between education and best care for patients, the hidden curriculum, and moral distress
- Self-awareness, including professional identity and self-care
- Management of challenging patients/family members, including recognition of what the clinician may be contributing to the difficulty
- Social media
- Religion and spirituality
- Acceptance of gifts from patients, including grateful patient philanthropy

Educational theory suggests that spacing and repetition of content improve learning.[39] A medical ethics and professionalism curriculum is therefore most likely to result in sustained changes in reasoning and behavior when it is longitudinal, such that early educational interventions are reinforced or advanced by subsequent exposures. For example, a method for ethics case analysis introduced in the first year of medical school could be reinforced in clinical clerkships by asking students to apply that method to analyze ethical issues they are encountering in clinical settings.

In addition, learner-driven teaching strategies should be considered. For example, learners could identify clinical cases with ethics issues for discussion and take an active role in facilitating case discussions.

Ethics and professionalism education must strive to move learners from knowledge acquisition and skills development to behavior change in which excellent patient care is the goal (by way of achieving the ACGME core competencies). This is challenging, but—to borrow from the language of theater—script does not become performance without rehearsal. After students gain medical knowledge in the classroom, educators commonly employ role-play scenarios (often with simulated patients or in an "ethics OSCE" [objective structured clinical examination][40]) to help students practice translating their medical knowledge into skills (and as a means for demonstrating that knowledge) before they encounter the complexity of actual patients.[41–43] This approach is highly effective for teaching ethics and professionalism.[44,45]

Technological advances have increased the variety of options for teaching ethics and professionalism. Some materials are now available online, such as recorded lectures[46] or formal ethics courses.[47] Educators are also creating online content for their own classes, and the "flipped classroom" approach (where students watch lectures online, on their own, saving class time for discussion and application of the material) may complement (or replace) the traditional approach of in-person lectures.[48] Educators should be open to these innovations and carefully evaluate which content is best delivered by new technologies. Advantages of moving lectures online include increasing both time for group discussions and the focus on students' critical thinking and behavioral skills during class. However, the use of innovative educational technologies may not be suited to situations in which learners do not consistently engage in outside preparation (e.g., busy residency programs with limited protected learning time). The wide range of available teaching methods gives educators opportunities to choose the pedagogical tools that are best suited to the jobs they are asked to do, but this variety also raises questions about which methods are most effective (an important area for future research).

Although it is not feasible in this report to offer a full account of how medical ethics education efforts should vary between GME and UME levels, it is worth noting some key differences. First, educational materials offered to residents can typically be more complex and contextual than those intended for medical students, and ethical issues can be more nuanced and discussed in greater depth. As a general point, educators

List 2

The DeCamp Report's Proposed Objectives of Medical Ethics Education[a]

- The ability to identify the moral aspects of medical practice
- The ability to obtain a valid consent or a valid refusal of treatment
- Knowledge of how to proceed if a patient is only partially competent or incompetent to consent or to refuse treatment
- Knowledge of how to proceed if a patient refuses treatment
- The ability to decide when it is morally justified to withhold information from a patient
- The ability to decide when it is morally justified to breach confidentiality
- Knowledge of the moral aspects of the care of patients with a poor prognosis, including patients who are terminally ill
- Additional areas considered for inclusion:
  - Distribution of health care
  - Abortion

[a]Objectives articulated in Culver et al, 1985.[1]

must recognize that any teaching session may involve learners at different levels of sophistication; accordingly, educators should tailor cases and teaching points to offer material appropriate to the range of learners with whom they are working. Second, differences in schedules and responsibilities require educators to adopt different approaches for teaching ethics and professionalism to medical students and residents. Whereas a variety of formats, including longitudinal courses, can generally be included in a medical school curriculum, finding opportunities for formal ethics and professionalism instruction can be more challenging in residency training programs where face-to-face educational sessions tend to take the form of sporadic, irregularly attended one-hour conferences. Although this conference format can be conducive to case-based discussions, educators need to be creative in turning these opportunities into a coherent curriculum.

Assessment Strategies

Faculty teaching ethics and professionalism cannot just assume that their pedagogical techniques achieve the intended goals. Rather, consistent with a broader trend in medical education, they are expected to demonstrate that what they are doing is working. Increasingly, they must justify the amount of curricular time allotted for medical ethics and professionalism education as well as any financial support they receive for such efforts.

Toward these ends, there is evidence that medical ethics education improves certain outcomes. Specifically, studies have shown an improvement in learner awareness,[49] attitudes,[50] knowledge,[51] confidence,[52] decision making,[53] and moral reasoning.[54] However, a more robust evidence base is required to examine the relationships between medical ethics education, physician performance, and—ideally—patient outcomes. Accrediting bodies, medical school deans, and residency program directors seek assessment tools to evaluate whether educational programs are effective in producing prepared clinicians. Further, it is in patients' interests to have (justified) confidence that their physicians have been trained adequately in ethics and professionalism.

A starting point for assessment is linking evaluation to learning objectives when doing so is possible and sensible. This requires careful consideration of the nature of individual objectives, whether individual objectives can be evaluated, and the complexity of the material being taught. If assessment is viewed as feasible, one model for linking learning objectives to assessment is the SMART approach[55]—creating objectives that are specific, measurable, action oriented, reasonable, and time bound. For example, "At the end of this session participants will describe the 5 components of the R.E.S.P.E.C.T. model for cross-cultural communication."[56] Objectives of this type reflect a focus on behavior-based educational goals, as discussed earlier, rather than an emphasis on character development.

Varied assessment strategies may be needed to determine whether ethics and professionalism learning objectives have been met. Possible strategies include, but are not limited to, learner self-assessment; learner reflection; evaluation of changes in learner empathy, cynicism, and attitudes; performance portfolios; traditional, knowledge-based exams; use of clinical evaluation exercises; use of OSCEs and other exercises with simulated patients; written feedback from faculty after small-discussion-group modules; and 360-degree feedback from peers, faculty, nurses, staff, patients, and families in the patient care context.[57–62] As noted above, an emerging assessment strategy is using defined EPAs to evaluate learner performance in the context of actual clinical activities. A recent article presents one institution's efforts related to medical ethics education to integrate goals, methodology, curriculum, and assessment.[23]

Although an expectation of performance-oriented assessment is challenging for many areas of the medical curriculum, it is especially challenging for ethics and professionalism: Some aspects of ethics and professionalism are not performance related, and even those aspects that are "behavorial" may be difficult to measure.[63] For example, some authors have pointed out that certain qualities of character desirable in any health care professional (e.g., humility, compassion, integrity, altruism) are not measureable in any conventional, quantitative sense.[64,65]

Further, evaluators of educational programs tend to focus on formal course work rather than the hidden curriculum,[66] and to look for *improvement* rather than *lack of erosion*. Yet, there is substantial evidence that manifestations of professional behaviors decrease throughout the medical socialization process.[64,67] Arguably, evaluation should also include assessing the learning environment of educational institutions[68] and measuring the ability of interventions to inoculate learners against diminishment of professional behaviors.[69]

Additionally, if the primary goal of medical ethics and professionalism education is improved patient care, we need to develop methods of connecting educational interventions to patient outcomes. One recent study provides an example of this by documenting a relationship between physician empathy and improved glucose control.[70]

If assessment is limited to what is formally taught and to what can be quantitatively assessed, or there is a requirement of positive change, we risk evaluating some of the most important qualities of professionalism in ways that fail to capture their nuances. Given this, some authors have argued for alternative strategies to assess the presence of such qualities and the corresponding success of educators' efforts to cultivate them in learners.[71,72] Clearly, there needs to be a good fit between what is being assessed and the strategies used to assess it. Quantitative ratings should not be the sole means to evaluate excellence in professionalism; rather, they should be complemented by qualitative assessments. This combined approach will enable richer, contextualized evaluations, but it also presents the challenge of identifying evaluators with the observational, perceptual, and analytical capabilities to conduct these assessments.

The phenomenon of latency also must be considered in the assessment of ethics and professionalism instruction: Outcomes of interest may not manifest themselves for years. One goal of medical ethics education is to prepare learners to address difficult ethical issues when they arise, yet learners may not encounter a particular ethics problem until years after they were taught about it in the classroom. However, their later performance may be profoundly affected by recollecting a distant reading or in-class discussion. This scenario creates challenges for evaluation. Accordingly, professionalism and ethics educators should develop long-term evaluation and/or research strategies to supplement the assessment of more immediate outcomes. In List 3, we propose items to assess and a "to-do" list (i.e., work to be done) with respect to assessment in medical ethics education.

Additional Challenges and Opportunities

Beyond the challenges we have already noted related to goals and objectives, teaching methods, and assessment strategies, additional challenges—as well as opportunities—exist in medical ethics education. First, training in ethics and professionalism exists within the larger context of the health care system and medical practice. Numerous external factors affecting doctor–patient

List 3

Assessment in Medical Ethics Education: Items to Assess in Medical Learners and a "To-Do" List

Items to assess

- Mastery of a basic body of medical ethics content
- Mastery of the intellectual skills for ethical analysis and reasoning/argument
- Performance in core bioethics behavioral skills: obtaining meaningful informed consent or informed refusal, assessing decision-making capacity, breaking bad news, analyzing a case with ethics issues, and using a shared decision-making approach with patients

Assessment "to-do" list

- Work with clinical colleagues to develop medical ethics components of passports and other learner self-assessment tools, as well as tools for faculty to use in assessing medical students' and residents' learning on clinical rotations
- Work with clinical colleagues on medical ethics components of tools for summative assessment of medical students and residents
- Work with colleagues who are specialists in medical education to ensure that medical ethics curricular design and assessment take into account variation in learning styles of adult learners
- Develop assessment strategies that address the relationships between medical ethics education and physician performance and patient outcomes
- Utilize a range of assessment strategies, both quantitative and qualitative, to ensure a "goodness of fit" between what is being assessed and the strategies used to assess it
- Develop long-term evaluation/research strategies to supplement assessment of more immediate outcomes (to address the phenomenon of latency)

encounters have negative influences on the learning environment and, thus, have the potential to undermine the foundation of medical education. When learners do not see what is taught in the classroom being honored in the clinical setting, they have difficult choices to make.[73,74] An institution's learning environment can either exacerbate moral erosion, burnout, and impairment among learners, or it can support learners by creating a culture that prioritizes learner well-being.[3] In response to this challenge, medical ethics and professionalism educators need to (1) provide learners with tools that can help them reconcile the mixed messages they may be receiving, and (2) measure, monitor, and improve their learning environments.[68]

Second, where and how to locate medical ethics and professionalism education in the overall curriculum of a medical school or residency training program is an important—and contested—issue. Careful consideration should be given to the timing and structure of this instruction and the level of expertise needed to deliver it.

Some medical schools have recently undertaken curricular revisions that reflect a philosophical change in approach to ethics education.[75] Instead of offering medical ethics and professionalism as a discrete course, instruction is woven

throughout the entire curriculum in a developmentally appropriate way. The justification for this integrated approach is that ethics is germane to all of medicine—from clinical decision making at the bedside and clinical investigations to policy considerations at the health care delivery system level—and should be incorporated into the curriculum wherever and whenever it is relevant.

There is considerable debate about the benefits and disadvantages of integrated approaches. It is important that ethics and professionalism education not be integrated into the curriculum to the point of being invisible, because students need to be able to identify the discipline of medical ethics and be familiar with its literature. In our view, the best practice may be to seek a healthy balance between emphasizing ethics and professionalism instruction and seamlessly integrating it into clinical education. However, appropriate incorporation of this content requires coordination with other course directors who may not be committed to its inclusion. Mechanisms must be put in place to ensure the inclusion of ethics material on other courses' exams and to enable formative and summative determinations of students' mastery of ethics and professionalism on an annual basis. Further, when ethics and professionalism teaching is woven into courses and clerkships directed by

non-ethics faculty, there are questions about who will be responsible for teaching this material, what level of expertise is needed, and how much time should be set aside for this teaching (in the context of busy schedules).

Third, faculty considerations factor significantly into the teaching and evaluation of medical learners. Successful medical ethics and professionalism education efforts require a sufficient number of faculty with appropriate training who are committed to establishing meaningful, ongoing relationships with learners to act as role models, share their own experiences, and teach, observe, give feedback to, and ultimately evaluate learners. Achieving success requires financial support, recognition, and reward for faculty educators. This is particularly challenging in an era of fiscal constraint because nonphysician faculty educators (i.e., those with PhDs and JDs) do not generate clinical revenue, whereas clinician educators tend to generate revenue by seeing patients, not by teaching. In some medical school settings, participation in medical education is implicitly devalued by the fact that teaching is a voluntary, nonremunerated activity—a discouraging message for all but the most committed educators. Until the issue of how to pay educators and reward them academically for their efforts is resolved, the quality of medical ethics and professionalism education efforts is likely to suffer.

Finally, faculty considerations are relevant when addressing expectations for assessment. If institutions strive for defensible *quantitative* evaluations of learner behavior, they need to ensure that there are enough qualified faculty observers to make a sufficient number of observations to achieve reliability.[60] Similarly, if assessment of some desired outcomes and qualities requires a *qualitative* approach, then faculty evaluators must be skilled at listening, observing, and "reading" learners to truly understand and "see" them.[76]

Moving Forward: Key Next Steps and Considerations

We believe that this report on the state of medical ethics education offers cause for optimism. In the three decades since publication of the DeCamp Report,[1] medical ethics

has become a core component of the medical school curriculum. Further, the emphasis on ethics in the ACGME's core competencies—especially the professionalism competency—indicates that medical ethics education is a valued component of residency training as well.

However, our report also identifies many challenges facing medical ethics educators. First, there is no consensus about specific educational objectives for medical ethics and professionalism. Second, several pedagogical methods have been shown to offer some benefit to learners, but the supporting data are rarely robust, and educational approaches vary greatly between programs and institutions. Third, increasing pressure to demonstrate effectiveness raises particular challenges for faculty teaching medical ethics and professionalism because these educational efforts do not always produce short-term, quantitatively measurable improvements. Finally, the "hidden curriculum"[66] can undermine learners' professional development, creating a need for attention to the learning environment and for widespread faculty development that would require significant resources and expertise.

Addressing these challenges requires a rigorous, systematic, and interdisciplinary approach. Although this is a daunting task, we propose the following research questions as first steps toward a comprehensive agenda for scholarship, both empirical (including qualitative and quantitative methods) and conceptual:

- *What specific role does medical ethics education play in supporting professional formation?* Research that answers this question would help focus medical ethics education efforts as they relate to professionalism and potentially provide a rationale for financial support.

- *What constitutes a consensus list of specific educational objectives for medical ethics education?* Research that establishes and leads to the dissemination of such a list would help ensure that all learners receive an agreed-upon basic level of medical ethics education.

- *What are the strengths and weaknesses of pedagogical approaches used in medical ethics education, and which are associated with better learner outcomes?* Research that addresses this issue would

help educators make informed choices from a long list of possible teaching strategies.

- *How are medical ethics and professionalism education associated with learner performance and patient outcomes?* Research that answers this question would help establish a much-needed evidence base linking education to outcomes. Such an evidence base could, in turn, provide additional rationale for financial support of these efforts.

- *What constitutes an evidence-based portfolio of effective medical ethics educational interventions for medical students, residents, physician faculty, and practicing physicians?* Work on this issue could lead to the creation of a helpful resource for educators who do not have time to develop a portfolio themselves.

- *Which assessment tools are most effective at measuring outcomes of interest in medical ethics education? Which assessment strategies should be paired with which learner and patient outcomes?* Research that responds to these questions would help educators select assessment strategies that are appropriate for the outcome of interest and proven to be effective. Work in this area should address the latency challenge noted above and recognize the limitations of quantitative measurement with respect to certain aspects of ethics and professionalism.

Another challenge is that few interinstitutional opportunities exist for medical educators to explore these problems and seek answers to these questions. One goal of the Academy for Professionalism in Health Care is to provide a forum for all stakeholders—including medical ethics, humanities, and professionalism educators—to come together to work on these challenging issues.[14]

In conclusion, we believe that the medical ethics curriculum can be improved by focusing it on professional formation as preparation for a lifelong commitment to professionalism in patient care, education, and research. It will require the hard work of many to ensure that medicine preserves its status as a caring profession that situates the needs of patients as its top priority.

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How Do Medical Schools Identify and Remediate Professionalism Lapses in Medical Students? A Study of U.S. and Canadian Medical Schools

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Abstract

Purpose
Teaching and assessing professionalism is an essential element of medical education, mandated by accrediting bodies. Responding to a call for comprehensive research on remediation of student professionalism lapses, the authors explored current medical school policies and practices.

Method
In 2012–2013, key administrators at U.S. and Canadian medical schools accredited by the Liaison Committee on Medical Education were interviewed via telephone or e-mail. The structured interview questionnaire contained open-ended and closed questions about practices for monitoring student professionalism, strategies for remediating lapses, and

strengths and limitations of current systems. The authors employed a mixed-methods approach, using descriptive statistics and qualitative analysis based on grounded theory.

Results
Ninety-three (60.8%) of 153 eligible schools participated. Most (74/93; 79.6%) had specific policies and processes regarding professionalism lapses. Student affairs deans and course/clerkship directors were typically responsible for remediation oversight. Approaches for identifying lapses included incident-based reporting and routine student evaluations. The most common remediation strategies reported by schools that had remediated lapses were mandated mental health evaluation (74/90; 82.2%),

remediation assignments (66/90; 73.3%), and professionalism mentoring (66/90; 73.3%). System strengths included catching minor offenses early, emphasizing professionalism schoolwide, focusing on helping rather than punishing students, and assuring transparency and good communication. System weaknesses included reluctance to report (by students and faculty), lack of faculty training, unclear policies, and ineffective remediation. In addition, considerable variability in feedforward processes existed between schools.

Conclusions
The identified strengths can be used in developing best practices until studies of the strategies' effectiveness are conducted.

Over the past three decades, professionalism has become a central theme in medical education and patient care. Medical schools and accrediting bodies are establishing professionalism standards, creating curricula, and performing assessments on physicians-in-training.[1–15] Once seen as the product of innate character traits, professionalism is now understood as a complex, dynamic, and evolving process based on the competing demands placed

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on individuals in the context of the organizational environment.[16]

Becoming a medical professional can be seen as a developmental process of "professional formation"[11,17,18] in which learners should gain knowledge from their mistakes. Evaluation of professionalism is complex, interpretive, and contextual, and it must take into account individuals, interpersonal relationships, and societal–institutional factors.[19] It is complicated by lack of consensus on a definition of professionalism in medical education.[20]

In 2004, Papadakis and colleagues[21] reported an association between unprofessional behavior in medical school and subsequent disciplinary action by a state medical board, underscoring the importance of addressing professionalism lapses early. In recognition of the importance of medical professionalism, in 2008 the

Liaison Committee on Medical Education (LCME) implemented standard MS-31-A (now element 3.5), requiring medical schools to detail the methods they use to develop, assess, and remediate professional attributes in medical students.[22]

Despite the mandate that medical schools identify and remediate professionalism lapses in medical students, little is known about best practices in remediation.[23] In 2012, an Alpha Omega Alpha Honor Medical Society think tank recommended (1) gathering data on existing remediation practices and (2) identifying current best practices in remediation for dissemination until formal evidence-based effectiveness research could be completed.[24] Such data are essential to answering critical questions, including but not limited to the following: How should professionalism lapses be reported? Who should make decisions about the need for

and the type of remediation? Who should conduct remediation? What methods should be used in remediation? How can the efficacy of remediation efforts be determined?

We sought to address this gap in the literature by exploring practices used to identify and remediate lapses in professionalism among medical students at U.S. and Canadian medical schools accredited by the LCME. Although issues related to medical student professionalism remediation extend beyond the United States and Canada, we chose to focus on schools required to meet the LCME standard.

Method

We conducted a mixed-methods study of LCME-accredited medical schools in the United States and Canada, using structured interviews to gather information about professionalism remediation practices. The Drexel University College of Medicine institutional review board determined that this study was not human subjects research.

Instrument development

We were not able to identify any published instruments that could address all of the data collection necessary for this study; therefore, we (D.Z., S.G., D.D., S.R., and D.N.) developed a specialized questionnaire for use in telephone interviews. We based the questions on Swick et al[13] and Bennett et al,[25] and we added additional questions through an iterative process. The questionnaire was pilot-tested in telephone interviews with deans at two institutions and modified on the basis of their feedback. Data collected during these pilot interviews were included in the analysis.

The questionnaire used in the first 47 interviews consisted of 16 questions, including closed- and open-ended queries, and was divided into four sections: policies regarding professionalism, identification of students with professionalism lapses, administrative response to lapses, and remediation of lapses. Respondents were asked about feedforward practices and about the strengths and weaknesses of their systems in handling professionalism lapses. After 47 interviews, we added 3 questions related to specific examples

of lapses to clarify student behaviors necessitating remediation. These additional questions were e-mailed to all previous respondents and were included in the telephone interviews thereafter. (For the final questionnaire, see Supplemental Digital Appendix 1 at http://links.lww.com/ACADMED/A278).

Participant recruitment

The 153 U.S. and Canadian medical schools accredited by the LCME as of April 25, 2012, were eligible to participate in the study. We obtained a list of these institutions' education deans, with e-mail addresses, from the Association of American Medical Colleges (AAMC). In June 2012, we e-mailed the dean responsible for medical student education at each school, explaining the study and requesting contact information for the key person(s) responsible for professionalism remediation at the institution. We followed up by e-mail to the nonresponding deans one and two weeks after the initial e-mail.

Once the key person at a given school was identified, we e-mailed that person to explain the study and invite participation in a 30-minute telephone interview. No incentives were offered for participation.

Participants received the questionnaire at least 24 hours prior to their interviews. Each interview was conducted by one of two research assistants (A. E., K.J.), who had received three hours of training from one researcher (D.Z.). Interviews were audiotaped with participant consent and transcribed. Data collection occurred between June 2012 and April 2013. One interview included two participants; as these individuals were at the same institution and participated together, we combined their answers and considered them to be one respondent.

Data analysis

We analyzed data using a mixed-methods approach. Quantitative data were deidentified and loaded into IBM SPSS version 20 (IBM Corp., Armonk, New York). An impartial third party reviewed all data entries; after this review, basic descriptive analysis was performed.

One author (D.Z.) reviewed 10% of the interview recordings to ensure transcription accuracy. We loaded transcripts into Atlas.ti version 7

(Scientific Software Development GmbH, Corvallis, Oregon) for qualitative analysis. Our qualitative analysis was guided by procedures based on grounded theory: open coding, memo writing, comparative analysis, and theory building.[26] One author (D.L.) coded all transcripts for themes; however, throughout the coding and analysis process, we (D.Z., D.D., D.L.) discussed emerging results to minimize the effect of a single-analyst bias when interpreting data and determining results.

Because of the large amount of qualitative data obtained, we chose to focus our initial qualitative analysis on (a) the controversial issues revealed by the quantitative data—anonymous reporting and sharing concerns about struggling students (i.e., feeding forward)—to better understand those areas; and (b) on perceived system strengths and weaknesses because we thought those might be useful in developing best practices.

We (D.D., D.L., D.Z.) used Papadakis's[27] proposed categorization of professionalism lapses, which is based on four behavioral domains, to organize responses regarding the most common lapses. The four domains are:

> 1) Responsibility (e.g., late or absent for assigned activities, missing deadlines, unreliable); 2) Diminished capacity for self-improvement (e.g., arrogant, hostile or defensive); 3) Relationship with patients including communication with patients; and 4) Relationship with healthcare environment (e.g., testing irregularities, falsifying data or impaired communication with team).[27]

Results

Participating medical schools

Ninety-three (60.8%) of the 153 eligible medical schools participated. Eighty-one of the 93 participating schools were in the United States (87.1% of sample; 59.6% of eligible U.S. schools), and 12 were in Canada (12.9% of sample; 70.6% of eligible Canadian schools). Participation rates differed slightly but not significantly by AAMC Group on Educational Affairs region: 28 schools were in the Northeast region (56.0% of Northeastern schools; 30.1% of sample); 27 were in the Southern region (54.0% of Southern schools; 29.0% of sample); 24 were in the Central region (68.6% of Central schools; 25.8% of sample); and 14 were

Table 1

Administrative Oversight of Remediation of Professionalism Lapses in Medical Students by Stage of Process, 93 U.S. and Canadian LCME-Accredited Medical Schools, 2012–2013 Study

Individual/committee	Oversight by stage, no. (%) of medical schools[a]				
	Is notified initially about lapse	Determines course of action after lapse	Devises remediation	Oversees remediation	Assesses outcome of remediation
Student affairs dean	69 (74.2)	54 (58.1)	46 (49.5)	48 (51.6)	45 (48.9)
Course or clerkship director	63 (67.7)	30 (32.3)	44 (47.3)	37 (39.8)	38 (41.3)
Medical education dean	19 (20.4)	26 (28.0)	17 (18.3)	19 (20.4)	16 (17.4)
Professionalism program director	5 (5.4)	8 (8.6)	9 (9.7)	10 (10.8)	9 (9.8)
Promotions committee	5 (5.4)	35 (37.6)	41 (44.1)	20 (21.5)	40 (43.5)
Honor court	4 (4.3)	9 (9.7)	9 (9.7)	6 (6.5)	6 (6.5)
Medical school dean	2 (2.2)	3 (3.2)	3 (3.2)	0 (0)	3 (3.2)
Other	6 (6.5)	9 (9.7)	12 (12.9)	9 (9.7)	11 (12.0)

Abbreviation: LCME indicates Liaison Committee on Medical Education.
[a]The total number of medical schools in each column is greater than the number of participating schools (n = 93) because some schools involved more than one administrator at each stage and/or had different system pathways depending on the student's progress through the medical education program (preclinical or clinical), the severity of the lapse, and/or the frequency of lapses. The denominator for percentage determination is 93, not the total number in each column.

in the Western region (77.8% of Western schools; 15.1% of sample). Participating schools' entering class sizes in academic year 2012–2013 ranged from 42 to 362 students, with most schools having between 100 and 200 students: 24 schools (25.8%) had entering classes of 100 to 149 students, and 32 schools (34.4%) had entering classes of 150 to 200 students.[28]

Ninety schools completed the questionnaire during a telephone interview, whereas 3 completed the questionnaire in writing. A total of 66 schools (71.0%) responded to the three questions about common professionalism lapses.

Policies and oversight

More than three-quarters of the schools (n = 74; 79.6%) had written policies and procedures related to unprofessional medical student behavior. Table 1 reports the administrative individuals or committees—such as student affairs deans, course or clerkship directors, medical education deans, professionalism program directors, promotions committees, honor courts, and others—involved at each stage of the professionalism lapse reporting and remediation process. At many schools, multiple administrators were involved simultaneously, especially at the initial notification stage. Student affairs deans along with course or clerkship directors were responsible for the majority of oversight.

Identification of professionalism lapses

Schools used various approaches to identify professionalism lapses in medical students, including incident-based reporting, routine student evaluations, separate professionalism courses and evaluations, formal peer assessments, and anonymous reporting. An overview is provided in Table 2. For students in the clinical years, sources of information on professionalism lapses included faculty, housestaff, other health care professionals, and patients and their families.

Respondents at half of the schools (n = 46/92; 50.0%) reported that their institutions had anonymous reporting systems (i.e., no information about reporter required). There were no statistically significant differences in the existence of anonymous reporting systems by geographic region

Table 2

Approaches Used to Identify Professionalism Lapses in Medical Students, by Phase of Medical School Curriculum, 93 U.S. and Canadian LCME-Accredited Medical Schools, 2012–2013 Study

Approach	Phase of curriculum	No. (%) of medical schools[a]
Incident-based reporting	Preclinical	82/93 (88.2)
	Clinical	82/89 (92.1)
Items on routine student evaluations	Preclinical: All courses	40/92 (43.0)
	Preclinical: Some courses	34/92 (36.6)
	Clinical: All courses/clerkships	88/90 (97.8)
	Clinical: Some courses/clerkships	2/90 (2.2)
Separate professionalism course and evaluation	Preclinical	14/91 (15.4)
	Clinical	14/88 (15.9)
Formal peer assessment	Preclinical	41/92 (44.6)
	Clinical	15/90 (16.7)
Anonymous reporting[b]	Preclinical and clinical	46/92 (50.0)

Abbreviation: LCME indicates Liaison Committee on Medical Education.
[a]Some participating schools did not yet have students in the clinical years, so respondents at those newer schools could not respond to some questions. Also, not all respondents at other schools answered all questions.
[b]Although respondents at half of the schools reported that their institutions had anonymous reporting systems, subsequent qualitative analysis suggested that some of these reporting systems were confidential rather than anonymous.

($\chi^2 = 3.67$, $P = .30$) or by entering class size ($\chi^2 = 3.25$, $P = .52$). Subsequent qualitative analysis suggested that some of these reporting systems were confidential (i.e., information about reporter required but kept confidential) rather than anonymous.

Common professionalism lapses in medical students

Although we did not ask for quantitative data on professionalism lapses, we did ask respondents for their perceptions of the three most common lapses at their institution. Respondents from 66 schools (71.0% of sample) provided 183 responses. Lapses in responsibility were the most common (n = 102; 55.7%). The behaviors cited most often in this category were missed deadlines, unexcused absences, and tardiness. Lapses in relationship with health care environment were the next most common (n = 59; 32.2%). The behaviors cited most often in this category were disrespectful communication (by e-mail or in person), inappropriate use of social media, and poor availability. Lapses related to diminished capacity for self-improvement were less common (n = 18; 9.8%); these behaviors consisted most often of lack of self-awareness (including of one's limitations), lack of initiative, and being defensive to feedback. Lapses in relationship with patients were rarely cited (n = 4; 2.2%).

In addition, some respondents reported lapses considered grounds for dismissal—as opposed to remediation—at their schools, including cheating on an exam (some schools did remediate this behavior), committing a felony, falsifying patient information or residency application information, forging prescriptions, or committing additional offenses after an initial lapse.

Remediation strategies

Respondents at 90 schools reported that their institutions generally used a combination of strategies to remediate professionalism lapses (see Table 3). Remediation assignments, used by 66 schools (73.3%), directed the student to read and write broadly about professionalism or focused on the student's lapse. Examples of assignments included reflective writing or directed reading, a literature review with a research paper or presentation, or

attending hospital ethics or state medical board disciplinary committee meetings.

Students were sometimes issued a set of behavioral standards or required to sign a remediation contract to explicitly acknowledge behavioral expectations and consequences of violations. Remediation was sometimes accompanied by probation, which could be noted in a dean's letter.

Mandated professionalism mentoring was employed at 66 schools (73.3%). Mentors included deans, faculty members, advisors, or course directors. Mentor–mentee meeting frequency was individualized depending on the situation; the number of follow-up meetings varied from three to weekly for the duration of medical school. In addition to meeting with the mentor, students were usually required to complete remediation assignments as described above. At 59 schools (64.8%), students were required to repeat part or all of a course or clerkship when professionalism objectives were not met.

Seventy-four schools (82.2%) mandated mental health evaluation/treatment and 65 schools (72.2%) required stress management counseling when it was determined that students needed that. Fifteen schools (16.6%) mandated community service; a number of respondents cited community organizations' reluctance to accept mandated students.

Feedforward practices

To understand how schools identify patterns of unprofessional behavior,

we asked whether information about a student with professionalism difficulties was made available to future supervisors (i.e., feedforward practices). Such information was shared at 49 schools (52.7%), whereas it was not at 39 schools (41.9%). At 5 schools (5.4%), decisions regarding forward notification depended on the student's stage of training and/or the type of lapse. There were no statistically significant differences in feedforward practices among schools by geographic region ($\chi^2 = 5.83$, $P = .44$) or by entering class size ($\chi^2 = 7.19$, $P = .52$).

Qualitative analysis of responses about feedforward practices revealed eight themes, reflecting the complexity of decision making surrounding these practices: (1) feeding forward only when certain criteria are met, (2) using feedforward mechanisms to support student learning, (3) feeding forward informally during meetings, (4) worry about creating biases, (5) feeding forward to residency programs, (6) struggles with feedforward policies, (7) deciding not to feed information forward, and (8) legal issues regarding feedforward policies.

Respondents at 20 schools (21.5%) reported that their institutions only feed information forward about professionalism offenses in certain instances. Some schools had formal policies for when to feed information forward; these policies often involved a written note system for formal documentation. Other schools left it to the discretion of the administrator(s) overseeing remediation to determine whether the severity of the offense required feeding forward or whether

Table 3
Strategies for Remediation of Professionalism Lapses in Medical Students, U.S. and Canadian LCME-Accredited Medical Schools, 2012–2013 Study

Strategy	Medical schools, no. (% of 90)[a]
Mandated mental health evaluation/treatment	74 (82.2)
Remediation curriculum or assignment	66 (73.3)
Mandated professionalism mentor	66 (73.3)
Stress management counseling	65 (72.2)
Repeat part/all of course/clerkship	59 (64.8)
Community service	15 (16.6)
Other	4 (4.4)

Abbreviation: LCME indicates Liaison Committee on Medical Education.
[a]Respondents at 3 of the 93 participating schools were not able to respond because these newer schools had not yet remediated any professionalism lapses in students.

feeding forward would serve the education and growth of the student. One respondent explained:

> [Previously problematic] behavior is tracked between clerkships. That information is passed onto the next clerkship. "John Doe struggled with such and such, place him with a strong mentor." In a supportive, not [punitive] way. It's more of, how can we put him with a good role model who will give him feedback early and continue the [supportive] environment?

Respondents indicated that feeding forward commonly occurred in informal circumstances, such as during regular meetings of clerkship directors. This practice was related to the theme of using information about lapses to support student learning because informal sharing may be a way to prepare future clerkship directors to provide additional assistance to students who may need it.

Some respondents mentioned the care taken in deciding whether to feed information forward due to worry about creating biases. For this reason, some respondents reported that information about lapses was restricted at their schools to individuals not directly supervising or grading students. Other respondents reported that this concern led to policies against feeding forward at their institutions. One respondent stated:

> This is a delicate problem if somebody has professionalism difficulties. We think it's probably not a good idea. Somebody having academic difficulties, that information gets passed forward. But somebody having professionalism problems, we try to have a clean slate going on to another clerkship.

Worry about biases was also related to feeding information forward to residency programs. Many respondents reported that their schools did not include professionalism offenses in information sent to residency programs unless the offenses were egregious or unresolved.

A few respondents discussed struggles with feedforward policies. One respondent boiled it down to an issue of responsibility:

> We talked about [whether to feed forward] and, rightly or wrongly, we've come together and said you know, our real responsibility is to the people of [this state] to which these individuals may one day be their doctors.

Although respondents at 39 schools indicated that information about professionalism lapses was not fed forward at their institutions, the qualitative analysis revealed that information was shared through informal mechanisms at most of these schools. Only a few respondents indicated that under no circumstances was information fed forward about professionalism offenses at their schools.

With regard to legal considerations, one school got legal approval before instituting a feedforward policy. Another school was working to navigate privacy legislation so that information could be fed forward to residency programs.

Faculty responsibility and training

Faculty at most schools were expected to play an integral role in identifying and addressing professionalism lapses in medical students, according to respondents. Twenty-seven schools (29.0%) had a formal policy that faculty should address professionalism lapses directly with students, and 60 schools (64.5%) had an expectation that this should occur. However, fewer than one-half of the schools (n = 32; 42.4%) had a formal program to prepare faculty for this role. Much of the training offered was described as optional and not robust (e.g., annual seminar on professionalism). A few respondents noted that their schools had infused professionalism education throughout the medical school curriculum; those schools had structured faculty development programs.

Determination of remediation success

Many respondents felt that criteria for successful remediation were not clearly defined at their schools. Success was determined by a variety of people, including direct supervisors, student affairs deans, professionalism mentors, and/or promotions committees, depending on the school and the type of lapse. Respondents at schools that issued behavioral contracts felt that success could be determined by the student's adherence to stated expectations.

Strengths and weaknesses of remediation processes

Respondents were asked to identify what they thought was working well and not working well with their schools' strategies for assessing and remediating professionalism lapses in medical students.

The four most common themes identified as strengths were catching minor offenses early to help students before problems escalate, emphasizing professionalism schoolwide, focusing on helping students rather than punishing them, and ensuring transparency and good communication. (Representative quotations for these and additional themes regarding strengths—including multiple sources of input, personal relationships, culture that encourages reporting of offenses, and feeding forward—are presented in Supplemental Digital Table 1 at http://links.lww.com/ACADMED/A279.)

Many schools concerned with catching minor offenses early employed a variant of the University of California, San Francisco, School of Medicine's Physicianship Evaluation system.[10,29] Use of such a system of routine reporting dovetailed with a school culture described as supportive and corrective, rather than punitive, toward students who lapsed. One respondent explained:

> Most critical is to understand that these are young people who need professional development and not punishment. They are not professionals yet. They are training to be professionals. Sometimes students don't understand how to act in the culture of a hospital [and may be] stressed out, tired and worried about grades and they sometimes do things in the heat of the moment that they normally wouldn't do.

Many respondents noted that transparent policies, including clear professionalism expectations and consequences for lapses, were imperative to ensure that students understood the importance of professionalism immediately and for their future careers.

Many weaknesses were related inversely to strengths. Four of the major themes identified as weaknesses were reluctance to report (among both students and faculty), lack of faculty training, unclear policies, and ineffective remediation. (Representative quotations from these and other themes—including lack of faculty accountability, lack of broad involvement, challenge to emphasize professionalism, and mentor-related challenges—are available in Supplemental Digital Table 2 at http://links.lww.com/ACADMED/A279.)

Reluctance to report lapses—typically attributed to a faculty member being

worried about harming a student's future or feeling uncomfortable confronting a student—was described as interfering with early identification of problem behaviors. Many respondents felt that reluctance to report could be overcome with better faculty training, which was another system weakness. However, several respondents noted that training clinical faculty with high turnover was challenging. Respondents believed that some faculty reluctance to report could also be overcome with clearer policies, such as policies with more detailed explanations of expectations for professional behaviors rather than broad generalizations. Remediation was thought by some respondents to be ineffective for students with certain personality traits.

Discussion

Interest in professionalism education, assessment, remediation, and research has burgeoned over the last three decades.[30] However, our findings indicate much variability in how schools are meeting the LCME standard for medical student professional development.[22] There is growing acceptance that "consistently exhibiting behaviors that reflect professional values requires sophisticated competencies that can and must be taught and refined over a lifetime of practice."[9] This professional development cannot be truly accomplished without appropriate assessment, feedback, and, when necessary, remediation.

To the best of our knowledge, our study is the first to systematically explore medical schools' professionalism remediation practices. Mechanisms for identifying and reporting lapses differed greatly among schools. Student affairs deans and course or clerkship directors were responsible for addressing the majority of lapses. Some schools relied on few identification strategies, whereas others had more elaborate mechanisms including telephone and Web-based systems for anonymous or confidential reporting, surveys, and routine student evaluations. All of these mechanisms are potentially flawed by differing conceptions of professionalism and reluctance to report. These factors compound the previously reported failure of clinical supervisors to fail underperforming trainees.[31] Peer assessment, despite its merits,[32] was used by fewer than one-half of schools participating in our study during preclinical training

and rarely during clinical training. Many respondents identified emphasizing professionalism schoolwide as key to a successful professionalism system, similar to findings reported in studies in clinical practice environments.[33,34]

Encouragingly, most medical student professionalism lapses appear to be minor. Lapses in responsibility were the type most commonly cited by our respondents, similar to findings of previous work.[35,36] Respondents struggled to balance the need to consider the individual context of each lapse and its corresponding remediation with the need to have a systematic process for addressing lapses. Many respondents identified addressing minor lapses early as important in helping struggling students understand how their behavior connects to the professional ideals of medicine. Respondents reported that their schools used numerous remediation practices, including reflective writing and meetings with a professionalism mentor, to help students make this linkage. The frequent use of strategies to address possible mental health issues is not surprising considering the high rates of depression, anxiety, and burnout among medical students.[37–39] Because of the complicated and individualized nature of professionalism lapses and remediation, most schools used nuanced approaches to feeding this information forward rather than adopting across-the-board feedforward policies, which is consistent with previous research.[40–43]

On the basis of our findings, we suggest the following next steps:

1. Create an online repository of examples of remediation policies and procedures, behavioral contracts, and remediation assignments. This would allow faculty, staff, and students to review and share successful practices and build on existing resources.

2. Provide faculty with training to enhance their skills and knowledge in addressing professionalism lapses and to encourage early reporting.

3. Conduct additional research to clarify factors contributing to underreporting so that these factors can be addressed.

4. Explore the risks and benefits of feeding information forward given that fragmented supervision of students makes it difficult to discern

patterns of behavior without sharing such information.

5. Conduct long-term studies of the effectiveness of identification and remediation strategies as measured through student outcomes.

Several limitations of our study must be noted. First, although our response rate was better than that of many comparable studies,[44] this study may be subject to sampling bias, including voluntary response and nonresponse biases. The former may have led to inclusion of schools more interested in professionalism; the latter may have led to the collection of data that reflect schools most active in professionalism reporting and remediation. Second, though we attempted to minimize the effect of "undercoverage" by considering school region and entering class size, the sample may not reflect all U.S. and Canadian LCME-accredited medical schools. Third, the complexity of the remediation process and the wording of some of our questions may have led to confusion among respondents given their variable levels of expertise. Finally, our findings may not be generalizable internationally because the study was limited to U.S. and Canadian schools.

Despite these limitations, our study has notable strengths. We gathered previously undocumented information regarding current practices used to identify and remediate professionalism lapses in medical students which can be used to inform further discussion. Schools can use the themes identified as strengths as the basis for developing remediation policies and procedures to address "minor" issues in a supportive environment and to develop essential training for faculty. This can transform faculty reluctance to report lapses to a positive approach focused on enhancing students' formation of professional identity. In addition, with increasing diversity of students, faculty, and staff as well as greater dispersion of educational sites, clear and open communication about professionalism expectations and norms is essential. The above-mentioned strategies could contribute to formulating best practices in medical student professionalism remediation. Finally, this study can provide a much-needed road map for future research and serve as the foundation for developing more

consistent practices for professionalism reporting and remediation.

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Humanism, the Hidden Curriculum, and Educational Reform: A Scoping Review and Thematic Analysis

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Abstract

Background

Medical educators have used the hidden curriculum concept for over three decades to make visible the effects of tacit learning, including how culture, structures, and institutions influence professional identity formation. In response to calls to see more humanistic-oriented training in medicine, the authors examined how the hidden curriculum construct has been applied in the English language medical education literature with a particular (and centering) look at its use within literature pertaining to humanism. They also explored the *ends* to which the hidden curriculum construct has been used in educational reform efforts (at the individual, organizational,

and/or systems levels) related to nurturing and/or increasing humanism in health care.

Method

The authors conducted a scoping review and thematic analysis that draws from the tradition of critical discourse analysis. They identified 1,887 texts in the literature search, of which 200 met inclusion criteria.

Results

The analysis documents a strong preoccupation with negative effects of the hidden curriculum, particularly the moral erosion of physicians and the perceived undermining of humanistic

values in health care. A conflation between professionalism and humanism was noted. Proposals for reform largely target medical students and medical school faculty, with very little consideration for how organizations, institutions, and sociopolitical relations more broadly contribute to problematic behaviors.

Conclusions

The authors argue that there is a need to transcend conceptualizations of the hidden curriculum as antithetical to humanism and offer suggestions for future research that explores the necessity and value of humanism and the hidden curriculum in medical education and training.

A s a conceptual tool, the hidden curriculum (HC) traces its intellectual heritage to the fields of sociology and education.[1] In the latter decades of the 19th century, sociologists began to direct critical attention toward understanding the impact of social structures on individual behavior and the overt and covert subjective meanings individuals attribute to their own and others' social actions. Later social scientists began to explore how some behaviors became popularized or normalized, tracing the relative impact of formal versus informal social norms and the pivotal role played by social relationships in the formation of group norms and culture.[2,3] These lines on inquiry led to work in the 1940s

and 1950s on how professional groups such as medicine were both formally and informally organized,[4] including the need to differentiate between the curriculum on paper and something academics were beginning to label the "informal curriculum."[5] It would be well into the 1960s, however, before the term "hidden curriculum" would make its first appearance.[1]

Studies in the field of education, with an eye toward discriminating between the formal and informal dimensions of educational practices, began to surface in the early decades of the 20th century. John Dewey[6] drew attention to the power of "collateral learning," a concept he used to describe learning that happens in the process of doing other things, alluding to the wealth of learning environments that exist outside the classroom. Concurrently, others began pointing to the "experience of curriculum in action,"[7] the impact of "informal education,"[8] and "the informal learning experiences in the school."[9] What emerged was a view of education as a

"sociocultural process"[10] in which both personality development and cultural reproduction coexisted as mutually influencing entities.[11]

The two earliest studies of medical education, *The Student–Physician* (1957) by Robert K. Merton and colleagues[12] and *Boys in White* (1961) by Howard Becker and colleagues,[13] had direct impact on what subsequently would be termed "the hidden curriculum." Merton's writings on manifest (conscious and deliberate) functions versus latent (unconscious and unintended) functions, his theory of unintended consequences, and his work on role modeling and modeling were direct precursors to work on the HC. For Becker, the linkages are more direct with his detailed earlier studies on educational settings and the influence of social stratification, social class, and social status on student learning[14,15] along with his subsequent scholarship on latent culture, latent social roles,[16] and the existence of a "student culture" in medical schools.[17] Finally, the role of "place" was

an important ingredient in the rise of the HC as a conceptual tool.

A critical mass of work on the HC began to emerge in the 1960s and early 1970s.[18,19] Today, the concept of the HC is applied to a wide variety of educational settings.[1,20–22] Issues using this lens stretch from admissions to accreditation and from the topic of the educational experience and professional identity formation to more point-specific topics such as CME,[23] faculty development,[24] the creation of the "worthy patient,"[25] and the production of heteronormativity during medical education leading to the privileging of heterosexuality and the marginalization of LGBTQ orientations.[26]

Scholarly work using the HC as an analytic lens remains more entrenched within education than sociology. In sociology the focus on implicit influences is related to "social systems," "social structure," and "organizational culture." Nonetheless, when either of these two disciplines attempts to wrestle with the more tacit dimensions of social life, including issues of socialization and cultural reproduction, along with the impact of factors such as power, hierarchy, and social class, both owe greatly to Marxist, feminist, and antiracist social analysis.[27,28]

Within this overall topography, issues of humanism have had an enduring presence in medical education, reflected in writing throughout the 20th century concerned with the balance between the "art" and "science" of medicine; whereas the art of medicine represents the relational aspects of care underpinned by a liberal education.[29,30] Focus on the art of medicine was temporarily eclipsed by the technological and pharmaceutical innovations that ushered in biomedicine, bringing with it an educational preoccupation with developing physician expertise through scientific training.[30,31] However, this preoccupation with science has been criticized steadily for the perceived effect it has had on physician and patient interactions. Today, calls for refocusing medical training on caring for the patient as a person appear regularly in literature pertaining to professionalism,[32–36] interprofessionalism,[37,38] ethics,[39,40] and empathy.[41–43] As the field of medical education developed the tools to understand how espoused values in

formal curricula could be undermined by educational and work practices, conversations related to the HC and humanism started to intersect, bringing us to our current exploration.

The aim of our paper is to (a) explore how the construct of the HC is framed and operationalized in the English language medical education literature as an analytical tool in relation to humanism and (b) describe the pedagogical mechanisms, objects, and processes proposed and practiced through the application of the HC concept in reform efforts to nurture and/or increase humanism in health.

Method

Compiling the archive

We used a scoping review and thematic analysis approach that draws from the tradition of critical discourse analysis to elucidate the conceptual and theoretical intersections of the HC and humanism in medical education.[44–46] Scoping reviews are broad explorations to systematically map a topic area, identifying key concepts, trends, and gaps. Critical discourse analysis is used to identify and describe patterns in the application of terms and concepts in texts.

The research team met several times to discuss how to sample for articles related to both the HC and humanism. Through consultation with a librarian, MEDLINE was searched using a combination of MeSH terms and free-text terms related to the HC (e.g., "hidden curricul*," "tacit curricul*," "Informal curricul") and humanism, for articles published from 1990 onward, and by limiting returns to six main research journals in the field of medical education, considered mainstream reading for medical educators: *Academic Medicine*, *Advances in Health Sciences Education*, *BMC Medical Education*, *Medical Education*, *Medical Teacher*, and *Teaching & Learning in Medicine*. We theorized that the date 1990 would be a good starting point for looking at the association between the concept of HC and humanism, as the first paper using a formal definition of the HC construct in health professions education appeared in *Academic Medicine* in 1994.[47] The research team, drawing on their combined experience with the topics HC and humanism, and together

with the librarian, devised a list of additional search terms including caring and compassion, patient/person/family centered, and empathy. We also included terms such as professionalism, ethical and/or moral erosion, and burnout, among other terms, as our combined experience with these literatures suggested that connections to humanism might also be found there. These constituted entry points for identifying articles that linked the concept of the HC with an interest in humanism. We were also attentive to alternate ways of thinking about humanism during our analysis phase. We included in the archive all types of articles (editorials, research papers, commentaries, discussion papers, etc.). Following this broad search we identified N = 1,887 articles as having relevance for this study.

Selection of articles for inclusion in the final archive was determined using a deductive approach: (a) We automatically included articles that directly focused on or explicitly mentioned the "hidden curriculum" or associated terms (informal, implicit, tacit curriculum) and addressed issues/topics related to humanism; (b) we also included articles that did not explicitly use the term "hidden curriculum" or its associated terms if authors of these articles made statements indicating that structures, culture, relationships, and the learning environment impacted in some way the socialization of medical students to a humanistic perspective; and (c) we excluded articles addressing issues/topics related to humanism (including how to teach humanism) if the authors of these papers did not relate their work to the HC, as per conditions "a" and "b" described above.

Our research associate (C.C.) consulted with one of the study investigators (T.M.) when there was uncertainty about the relevance of a particular article to the research; thus, T.M. sorted a significant portion of the archive. We further delimited the study during the analysis phase (see below). Sorting of the articles (regarding inclusion/exclusion and categorization) also constituted a sensitizing phase (i.e., familiarization with the literature included in our archive and the deeper level of sorting to begin identifying/developing actual codes) to particular issues, topics, and concepts that serve as "connective tissue" between the

HC and humanism. Initial parameters for the first phase of analysis were based on several discussions among the research team. Team members drew on their own respective experiences with both the concepts of the HC and humanism, while the research associate (C.C.) and medical student (J.L.) drew specifically on their initial impressions from reading the literature included in our archive. From these discussions, broad categories for coding were identified/developed and then uniformly applied to the entire data set (see Supplemental Digital Appendix 1 at http://links.lww.com/ACADMED/A301).

We removed articles from the archive that did not help us address at least one of our study objectives. As the analysis progressed we made a further delimitation to the archive: (d) We excluded articles related to professionalism that referenced explicitly or implicitly the HC and its associated terms, but did not relate to caring and compassion attributes of humanism. Following this three-tiered sorting process, we identified N = 200 articles as directly relevant to our study. These constitute our final archive (see Supplemental Digital Appendix 2 http://links.lww.com/ACADMED/A301).

Analysis

During the sensitizing phase, three team members (C.C., T.M., B.M.) read the same N = 10 articles to identify how authors were using the terms HC and humanism. They presented very similar findings/codes and a high degree of agreement regarding code conceptualization by working together to consolidate coding terms and phrases. Core areas of focus started emerging including a perceived conflation between professionalism and humanism, a strong focus on managing the HC to avoid erosion of humanistic attributes, and a wide array of attributes associated with humanism. The analysis continued with C.C., T.M., J.L., and B.M. randomly selecting an additional 100 articles (25 articles each) to be read and coded. Once again, the four members recorded very similar findings related to the emergent categories of focus and the previously agreed-on open codes and subcodes. Their observations were discussed with the entire team, and a final coding structure was determined which included codes related to definitions of the HC and humanism, actions taken to manage the HC, targets of these actions

(i.e., individual, curricular, culture, system, theoretical), and links between the HC and humanism. The team also kept track of who was writing about the intersection of the HC and humanism, the disciplinary background of the scholars, and the attributes that scholars associated with humanism. The final stage of analysis included application of these codes to the entire database by J.L. in consultation with T.M. and tabulating the results into visual representations to ascertain trends that cut across the entire data set.

We provide detailed demographic information below related to our final archive and address each of our aims individually to provide a clearer and more concise discussion on the interaction of the concepts of the HC and humanism within medical education literature.

Results

Demographic findings

The majority of the articles in our archive were published after 2000 and in the journal *Academic Medicine* (see Table 1). A little over 30% of the texts were review articles or discussion pieces, with no empirical data. A few of these included formal literature reviews, though the majority were narrative, topical, or historical reviews and general discussion pieces. Of the empirical articles, most were qualitative research studies (approximately 25%) employing a variety of methodologies and methods including case study, interviews, and observations. The quantitative studies (approximately 12%) in our archive primarily used survey methods or inventory/scale results. About 12% of the archive consisted of descriptions of curricula, programs, or tools. Of these, a few were formal program evaluations. Commentaries and letters to the editors made up less than 12% of the archive (see Supplemental Digital Appendix 1 http://links.lww.com/ACADMED/A301). There was a wide breadth of geographic focus in our archive with papers commenting on or exploring learning contexts from around the world—namely, Australia, Canada, Finland, India, Italy, Lebanon, Malaysia, the Netherlands, Saudi Arabia, Scotland, Slovenia, Sri Lanka, Sweden, Taiwan, Uganda, the United Kingdom, and the United States. However, most papers (66%) focused specifically on Canada or the United States. We made note of the

Table 1
Archive Demographics

Characteristic	No. of articles
Article inclusion	
Articles identified from literature review	1,887
Excluded from analysis	1,687
Included in analysis	200
Article inclusion by journal	
Academic Medicine	123
Medical Education	42
Medical Teacher	14
Advances in Health Sciences Education	8
BMC Medical Education	8
Teaching and Learning in Medicine	5
Article inclusion by date range	
1990–1994	5
1995–1999	25
2000–2004	38
2005–2009	65
2010–2014	67

disciplinary locations of all authors as far as it was possible to determine from their departmental affiliations and, when available, their educational credentials. Some individuals provided multiple disciplinary affiliations either through appointment or training. From this demographic coding we determined that our archive reflects a dominant medical education/clinical viewpoint (i.e., authors with MD degrees working in teaching or educational leadership positions and/or appointed to medical education centers/divisions; authors with other clinical expertise such as nursing, occupational therapy, and pharmacy), with contributing perspectives from individuals with backgrounds in behavioral sciences, social sciences, and humanities. Specifically, there were authors in our archive with backgrounds in cognitive science, psychology, social psychology, sociology, epidemiology, history, law, philosophy, anthropology, biomedical informatics, English, and literature.

The HC applied as a conceptual tool: Professionalism and humanism conflated

We kept track of the different ways the concept of the HC was defined and operationalized by authors. In 90%

of the archive, we found references to the "hidden curriculum," "informal curriculum," "medical culture and enculturation," and "institutional values" as operating for or against the goals of the formal curriculum. For example, one author defined the HC as comprising "the commonly held understandings, customs, rituals, and taken for-granted aspects of what goes on in the life-space we call medical education"[48(p44)] while another described it as "the physical and workforce organizational infrastructure in the academic health center that influences the learning process and the socialization to professional norms and rituals."[49(p124)]

In the remaining 10% of the articles we noted explicit and implicit references to learning taking place outside the formal curriculum or mentions of learning as a product of peer effects.[50–51] Nevertheless, negative effects of the HC were closely associated with professionalism lapses and unethical behaviors, which may account for the numerous recommendations we found in our archive for better teaching and regulation of professionalism as a way to promote humanism. Indeed, only two authors in our archive attempted to disentangle professionalism from humanism, and they disagreed fundamentally with how interrelated the two concepts should be considered.[52,53] Finally, in more recent years, HC references reflect an appreciation that individual behaviors are a product of complex social–political relations involving institutions and organizations, with implications, as we discuss below, for how reform was approached.

We recorded the terms authors used to refer to a humanistic orientation, attitude, or ideal. As with the HC construct, authors explicitly or implicitly referenced humanism in their papers, making statements such as that "caring, respect, effective communication and integrity" are "values of quintessential importance in defining the humanistic qualities of physicians,"[54(p942)] and "Integrity, honesty and empathy are the basic qualifications needed to practice ethical medicine."[55(p759)]

Over 80 attributes and values were listed in various combinations by authors who argued that it was important to cultivate or preserve a humanistic orientation

in aspiring physicians (see Box 1). Most authors referenced a humanistic orientation by referring to the need to demonstrate "compassion" and "respect" towards patients. Also popular were the terms "professional," "empathetic," "altruistic," "caring," and "ethical."

To discern how the identified attributes/values relate to medical training, we decided to map the terms onto the CanMEDS competency framework.[56] We chose the CanMEDS framework because most of our archive related to a North American context, the competency framework is currently used in Canada and several other parts of the world, and it aligns well with the ACGME competencies. We discovered that most of the attributes and values listed in our archive in association with a humanistic orientation corresponded to competencies associated with the roles of Professional and Communicator. Specifically, the role of Professional includes the expectation that medical students and residents "exhibit appropriate professional behaviors in practice, including honesty, integrity, commitment, compassion, respect and altruism." Correspondingly, one of the key competencies of the Communicator role includes the imperative to "develop rapport, trust and ethical therapeutic relationships with patients and families." In other words, the conflation we noted in our archive between professionalism and humanism may be a by-product of educational organization because competency frameworks in medicine are used to order, delimit, and regulate educational processes. Interestingly, while the enabling competency of "demonstrating compassionate and patient centred care" appears under the role of Medical Expert, very few other attributes identified as important to a humanistic orientation in our archive (i.e., "competence," "excellence," "humane," "responsible," and "skilled") relate to this role. As well, while humanism is thought to be tied to exposure and engagement with humanities disciplines, and the HC as an analytical term emerged from the social sciences, only 7 of the 200 texts in our archive recommend revising the formal curriculum, which to a large degree underpins the expertise of physicians, to include a stronger concentration of humanities and social science teaching. A number of questions are thus raised

with regard to the particular associations engendered by the use of the HC when considering humanism in medicine, which we will consider below.

Dueling concepts: The HC and humanism intersect

While we encountered diversity in the way the HC was conceptualized and defined (reflective perhaps of the disciplinary diversity of the authors engaged in this writing), we also found a dominant thrust in conceptualizing the HC as antithetical to humanism—a carrier of dehumanizing effects engendering a "thickening of the skin" necessary for surviving contemporary medical practice (and medical education). The HC personified as a teacher of professionalism was conceptualized as needing regulation and management. The HC described at the level of phenomenon was described as something generalizable to include loss of idealism, ritualized professional identity, emotional neutralization, erosion of ethical integrity, acceptance of hierarchy, and learning of what is "really" valued as "good doctoring." It was often approached as a phenomenon needing to be understood, its mechanism exposed in order to be contained. When the HC was conceptualized as a relational construct and associated with enculturation of medical students, it was often disassociated from institutional, structural, and systems issues. Rather, teachers were held accountable for failing to role model the espoused ideals of the profession.[57]

However, when the HC was conceptualized as broadly including effects of structure, organization, and culture, authors were more likely to make references to needed reforms at the level of the institution.[58] Although tacit learning can positively reinforce messages received in the formal curriculum, we did record a preoccupation in our archive with harmful effects of the HC. The HC was largely perceived to teach through mistreatment and negative role modeling, in the process stamping out innate humanistic tendencies of medical students. References to erosion of humanism were present in diverse interrelated conversations including the overspecialization of medicine and medical practice, the standardization of medical practice, the overreliance on technology in diagnosing, and the intolerance for uncertainty. Some authors

Box 1
Attributes/Values Associated With Humanism

Acceptance	Communication	Diversity	Honest	Neutral	Self-aware
Accountable	Compassionate[a]	Duty	Honor	Non-judgemental	Self-care
Advocate	Competence/excellence	Egalitarian	Humane	Openness	Sensitive
Altruistic[a]	Confidentiality	Emotional intelligence	Humble	Patient Education	Service
Attentive	Conscientious	Empathetic[a]	Inclusive	Patient Relationships	Skillful
Authentic	Considerate	Engaging	Integrity	Patient-Centred	Sociable
Autonomy	Cooperative	Enthusiastic	Intellectual	Polite	Social responsibility
Beneficence	Courage	Equanimity	Interested	Present/Mindfulness	Supportive
Calm	Courteous	Ethical[a]	Introspective	Professional[a]	Sympathetic
Caring[a]	Culturally sensitive	Fair	Kindness	Reflective	Teamwork
Cheerful	Curious	Fidelity	Knowledgeable	Relationships	Tolerance
Civic duty	Dedicated	Flexible	Leadership	Reliable	Trust
Collaborative	Dignity	Funny	Learning	Respect[a]	Understanding
Comforting	Diplomatic	Generous	Listener	Responsible	
Commitment	Disciplined	Genuine	Moral	Scholarly	

Representative examples from archive documenting the use of terms in relation to humanistic orientation[b]:
- "An ethic of caring requires physicians to be willing to listen to patients with empathy and compassion, and to take responsibility … students are learning to care: to advocate, to empathize, to attend to needs, however small; in other words they are learning to be receptive and responsible." (Konkin et al, 2012, p 594)
- "As a group, these faculty members embraced empathy, compassion, fairness, and courage." (Higgins et al, 2011, p 241)
- "For young physicians to become more humane and effective healers, they must demonstrate professional conduct." (Coulehan, 2005, p 893)
- "But also mandated are competencies that nurture humanistic values, such as moral reasoning and ethical judgment; communication; professionalism and role recognition; and self-awareness, self-care, and personal growth." (Cooper et al, 2007, p 322)
- "… competence depends on habits of mind, including attentiveness, critical curiosity, self-awareness, and presence; that it includes the cultivation of emotions, values, and reflection in daily practice." (Browning et al, 2007, p 906)
- "The qualities of the good physician in this formulation were captured in eight categories: (1) altruism, (2) responsibility and accountability, (3) excellence and scholarship, (4) respect, (5) honor and integrity, (6) caring/compassion/communication, (7) leadership, and (8) knowledge and skills." (Karnielli-Miller et al, 2011, p 370)

[a]Denotes most referenced in relation to a humanistic orientation.
[b]Full citations can be found in Supplemental Digital Appendix 2 at http://links.lww.com/ACADMED/A301.

specifically related the dominance of biomedicine to the denigration of "nonscientific topics, such as medical history and the social-cultural contexts of medicine."[59(p212)]

The HC as "the real teacher" is understood to socialize students to what is "actually" valued in medical education and medical practice. Ironically, this positioning of HC effects displaces the role of the formal curriculum as the foundational underpinning of medical training. Indeed the "real teaching" is perceived to happen implicitly, making the "real curriculum" hard to find and to revise, unless all teachers are targeted as needing to be better regulated. A physician can be clinically knowledgeable and not be humanistic, and still be successful in the system, while a humanistic physician who is not clinically competent will fail. This is the message received very early on by students, and it is knowledge that they need in order to succeed in their studies. As one author noted, the "prevailing metaphors of medical education continue to be heavily mechanistic (the body is a machine), linear (find the cause, create an effect), and hierarchical (doctor as expert), while its dominant narrative tends to be a story of restitution (patient becomes ill; patient is cured by physician expert; patient is restored to pre-illness state)."[60(p194)]

Thus, students receive implicit messages that humanism is secondary to clinical scientific knowledge.[59] Therefore, if the

HC is indeed a prime mechanism by which students are socialized into the profession (as suggested by the literature), challenging the HC is potentially risky because doing so entails critiquing the medical profession's traditional agenda, most notably how the profession's self-interest is preserved through the cultural reproduction of sociopolitical relations, including medicine's alignment with science. However, despite the potential tarnish to medicine's good name, scholars within and outside of medical education have taken aim at the HC through various reform efforts. We now explore the *end* to which the concept of the HC has been used in educational reform efforts (at the individual, organizational, and/or systems levels) related to nurturing and/or increasing humanism in health care.

The HC and humanism-based reform efforts in medical education

Analyses of the literature revealed that discussions of HC and humanism-based reform efforts could be grouped into three distinct, yet related, thematic categories: (1) the objectives of the reform efforts (e.g., to increase humanism, thereby thwarting aspects of the HC; to dilute elements of the HC to allow the growth of humanism); (2) the mode/format of the reform efforts (e.g., programs, courses, extracurricular initiatives); and (3) "who"/"what" the reform efforts are targeting (e.g., students, faculty, curriculum/structure, culture of organization).

We found that the majority of reform efforts are aimed toward enhancing humanism among medical students—primarily through formal programs, courses, and seminars.[61,62] The structure and nature of these reform initiatives range from embedded curricula that attempt to engage students in humanism-based exercises and experiences throughout the four years of their undergraduate medical training, to episodic reflection exercises and one-time/stand-alone short-term seminars. A few articles suggested exposing medical students to more humanities-specific *disciplines* (e.g., history, art, music, philosophy) [63–70]; however, almost all reform-based efforts featured in the literature strove to promote individual-level humanistic *attributes* (e.g., empathy, compassion, integrity, respect). Although medical students are the primary target

of programmatic reform efforts, there are also initiatives designed to promote humanistic traits and behaviors among medical school faculty and staff.[71] These faculty-based reform initiatives were focused on cultivating positive role models, advisors, and mentors that will exhibit humanistic traits to students, and, similar to the student-based reform efforts, were not oriented toward engagement with principles and ideologies of the humanities disciplines.

What is somewhat absent from the literature, however, are details regarding how the now humanism-enhanced students and faculty actually will thwart elements of the HC nested within medical education. Rather, it appears either assumed or treated as nonproblematic that the increased presence and practice of humanism among the medical school populace will somehow obstruct the "teachings" of the HC.[72–75] Although the remedial programs/courses often are outlined in great detail, there is little specifically as to how these students and faculty newly knighted in humanism (through reflection, readings, group exercises, simulated patients, etc.) will dismantle the deleterious conditions and effects of the HC.

Efforts directed toward diluting aspects of the HC to allow humanism to blossom frequently feature a call to vanquish perceived HC-based noxious elements nested within medical training such as negative role modeling and status hierarchies among health care professions. The assumption is that such efforts will automatically promote an institutional ethos of equality, cooperation, openness, and professionalism. Within this realm of reform-based literature, elements and "teachings" of the HC are perceived as detrimental to students' socialization and professionalization, particularly with regard to the development and maintenance of their other-oriented attributes, like humanism, and therefore must not only be "outed" but dismantled. Proposed approaches include removing or altering certain ceremonies (i.e., the white coat ceremony); significant reformation of medical school admission practices; exploration of institutional resource allocation (e.g., space, appointments, promotions); examining siloed learning environments and systems; critically evaluating assessment instruments and practices; and the dissection and

deconstruction of "slang," "med speak," and institutional jargon. However, very few studies within our database featured any of these directives as operationalized "interventions." Therefore, little is known as to the actual impact these strategies would have on the HC.

As noted above, curriculum and programmatic-based reform (e.g., formal course/exercises, role model training, interprofessional education initiatives) appear to be the weapons of choice to confront the HC (by enhancing humanistic attributes among institutional players[76–82]). Nonetheless, these reform efforts have stressed microlevel, individual- and group-oriented change. Less attention has been paid to structural- and organizational-based reform (meso- and macrolevel) to dilute or alter aspects of the HC through addressing and reshaping institutional culture and nested hierarchical boundaries, or providing an institutional atmosphere/climate for humanism to flourish. In short, reform efforts have been more oriented toward a bottom-up approach than a top-down one. In this sense, a majority of the reform-based literature in our archive appears to conceptualize learners (medical students) as needing protection from negative role models and the dehumanizing effects of socialization into medicine.[83–88] As such, students rarely are discussed as active participants in their education and training. Rather, they are portrayed as innocent, passive victims of the debilitating effects of HC, lacking socioemotional resilience, and requiring extra efforts to cultivate humanistic traits. This dissection of the HC offered above suggests that the HC is something that is "done to" students. It is therefore not surprising that a majority of the reform efforts are also aimed at trying to "do something to" medical students (i.e., enhancing humanistic attributes and characteristics through formal instruction), rather than addressing the overarching institutional culture.

Discussion and Future Directions

Suggested solutions to HC "ills" are nested within better teaching of professionalism and ethics, a stronger concentration of reflective practice, stronger regulation of teachers, and, more recently, the infusion of social science and humanities teachings among other recommendations. All

of these proposed solutions live at the individual or organizational level, and very few call into question "systems"-level matters concerning, for example, the basic structure or funding mechanisms of the profession. The conflation of professionalism and humanism we noted in our archive may account for the disproportionate focus on interventions to "fix" behaviors, suggesting the need to explore this conflation more systematically.

The largely North American perspective of our archive suggests that relating humanism to professionalism may be culturally specific to this region. Although other regions were represented in our archive, our sampling approach limits our capacity to draw out the context-specific dimensions of the application of the HC concept as an analytical tool and ways in which humanism is defined in different cultures. These are important aspects to explore moving forward because patient-centered care is closely associated with cultural representations of health and illness. Correspondingly, our demographic analysis made visible that medical educators through their collaborations are drawing on and using sensitizing concepts and perspectives from an array of disciplines to inform medical education practice in relation to humanism. Exploring systematically what each of these disciplinary perspectives has contributed to this topic can help us set a research agenda for pursuing evidence-based educational and health practice in relation to issues of humanism.

Programmatic exercises (like portfolio work and reflective practice skill building) are injected into the curriculum as a way to teach students to manage HC effects. These recommendations are premised on the largely unproblematized assumption that medical students are passive participants in their enculturation, their humanistic qualities and moral compass eroded and stamped out of them through close association with negative role models (their teachers) and the stressors associated with medical training. Although not prevalent in the literature, students are sporadically conceptualized as knowers, their experiences providing a direct entry to the effects and operations of the HC and their actions often changing medical culture for the better.[89] Conceptualizing students as agents of their learning

provides a novel entry point for studying professional identity formation as a dynamic process. Sociocultural learning theories provide pathways for examining the HC and humanism intersection through research that explores resiliency among learners and how students may challenge and subvert harmful influences in their daily practice and interactions with their preceptors, peers, and learning environment. This shift may also encourage medical educators to broaden their scope of practice beyond considerations of curriculum and pedagogy, to think about education as a sociopolitical endeavor—a starting point for interrogating how systems, structures, and institutions impact socialization and professionalization processes. In addition, there are many untapped dimensions of tacit socialization and learning that may contribute to conversations about humanism, in particular work that aims to understand and counter issues of racism, classism, gender, and other discrimination in medical training and health practice. These topics, as discussed in our overview of the HC tradition, are important dimensions of tacit socialization that have immediate implications for how physicians train and practice.

The intersect between the HC and humanism often is presented as a zero-sum game—boosting humanistic traits among institutional players who will, in turn, vanquish the HC and/or dismantle elements of the HC to allow humanism to flourish. From this perspective, a medical student can either retain his or her humanistic qualities or become enchained by the noxious tangles of the HC. In short, the literature suggests that medical education is inimical to the HC. However, we agree with authors in our archive who question this relationship.[89] We propose that the "teachings" of humanism in its broader meaning (as the name for a broad range of fields of learning and inquiry) are complementary to the "teachings" of the HC rather than antithetical. Perhaps, like most things, there is a necessary balance, in this case between the promotion of those traits named "humanistic" and the realities of medicine to which the HC responds. In this sense, future research should explore the role(s) of the HC in medical education (i.e., the manifest and latent functions)—not just as an "evil machine" that grinds up fragile hapless medical students or residents and spits them

out, but as a mechanism that provides an equilibrium to our future physicians, balancing what we want and what is possible. In other words, "the hidden curriculum hides in the gap between the ideal and the real practice of medicine, and it provides the lessons that students and educators need for the everyday work of medicine."[90(p60)]

In this paper we explored the conceptualization and operationalization of the HC as it relates to humanism, and spotlighted the themes associated with reform efforts regarding the HC and humanism. We found, with respect to both study objectives, a battle between "good" (humanism) and "evil" (HC) being waged on the terrain of the individual—a battle that continues despite the extensive amount of research and attention (as featured in this scoping review). This preoccupation with managing HC effects obfuscates the positive effects of latent socialization and informal learning, including the many ways that educators and learners learn to navigate contradictory messages about what is right and what is possible, while managing, and perhaps most important, challenging the realities of contemporary health care. Moving forward and beyond, as scholars continue to explore the intersect between the HC and humanism, we suggest starting from the position that it is both necessary and valuable for humanism and the HC to coexist within medical education and training, especially as we strive to empower health professionals to advocate for their patients and contribute to changes in the way health care is organized and delivered.

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Is Reflective Ability Associated With Professionalism Lapses During Medical School?

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Abstract

Purpose
Recently, many have argued that learning to reflect on one's experiences is a critical component of professional identity formation and of professionalism. However, little empirical evidence exists to support this claim. This study explored the association between reflective ability and professionalism lapses among medical students.

Method
The authors conducted a retrospective case–control study of all students who matriculated at Indiana University School of Medicine from 2001 to 2009. The case group (n = 70) included those students

who had been cited for a professionalism lapse during medical school; the students in the control group (n = 230) were randomly selected from the students who had not been cited for a professionalism lapse. Students' professionalism journal entries were scored using a validated rubric to assess reflective ability. Mean reflection scores were compared across groups using t tests, and logistic regression analysis was used to assess the relationship between reflective ability and professionalism lapses.

Results
Reflection scores for students in the case group (2.46 ± 1.05) were significantly

lower than those for students in the control group (2.82 ± 0.83) (P = .01). A lower reflection score was associated with an increased likelihood that the student had been cited for a professionalism lapse (odds ratio = 1.56; P < .01).

Conclusions
This study revealed a significant relationship between reflective ability and professionalism, although further study is needed to draw any conclusions regarding causation. These findings provide quantitative evidence to support current anecdotal claims about the relationship between reflection and professionalism.

Reflection has been widely cited as an essential component of professionalism in medicine and other health care professions,[1–5] and it has been proposed as a tool to help students learn to distinguish between positive and negative role models and to reconcile the conflicting messages from the formal, informal, and hidden curricula.[6] Although many have described the activities or processes that constitute reflection, in this study, we consider it to be an exploration and appraisal of one's own and others' experiences for the purpose of clarifying or creating meaning.[7] Reflection is a process by which one's thoughts are "turned back" to an event or experience so it can be analyzed and interpreted to gain a new or better understanding. The insights gained during the reflective process then can be applied to similar situations in the future with the goal of improving

outcomes.[8] The stimulus for reflection is often some "disorienting dilemma" that causes one to question one's knowledge and assumptions about a situation.[9] The discrepancy between one's idealized notion of medicine and the reality of medical practice provides such a stimulus for medical students, and reflecting on this dichotomy often can help them navigate among their experiences and ultimately accept or reject elements of the hidden curriculum.[10,11]

Reflective writing as a tool to promote and assess professionalism is growing in popularity among medical schools. A 2008 survey found that 35% of internal medicine (IM) clerkship directors required students to engage in reflective writing during their clerkship, indicating a belief that the practice helped students to develop communication skills and professionalism. Another 16% indicated that they planned to implement reflective writing curricula within the next two years.[12] Indiana University School of Medicine (IUSM) introduced reflective writing into the IM clerkship curriculum in 2004. The goal of the reflective writing assignment, which took the form of an online professionalism journal,

was to heighten students' awareness of professionalism issues by encouraging them to reflect on and learn from their experiences.

Although many medical schools have introduced reflective writing curricula to foster students' professional development, the evidence to support this practice is largely anecdotal; no studies have provided empirical evidence that reflection enhances students' professionalism or, more important, that a lack of reflection increases the risk of professionalism lapses. The purpose of this study was to examine the relationships between reflection and professionalism using a case–control study design that compared the reflective ability of students who had been cited for professionalism lapses and those who had not. We hypothesized that students who had been cited for professionalism lapses would have lower reflection scores than those who had not been cited for such lapses.

Method

Evaluation of professionalism at IUSM

At IUSM, professionalism and other noncognitive aspects of medical education (e.g., teamwork and communication

skills) are part of a formal competency-based curriculum.[13] As part of this system, the Student Promotions Committee (SPC) was charged with evaluating competency deficiencies among students and referring them to qualified individuals for remediation. Between 1999 and 2009, 191 students were referred to the SPC for 317 separate competency deficiencies. Deficiencies in professionalism, self-awareness, and moral reasoning were the most frequently cited, accounting for over 55% of all citations (29.3%, 17.7%, and 9.1%, respectively).[14] Students who had multiple citations often were cited for deficiencies in more than one of these areas, suggesting that self-awareness and moral reasoning are closely related to professionalism. Current definitions frequently include self-awareness, ethics, and moral judgment as specific domains under the umbrella of professionalism,[3,15] which prompted us to include all three competency areas—self-awareness, moral reasoning, and professionalism—as "professionalism-related competencies" for the purposes of this study.

The conceptual model of professionalism used by IUSM was adapted from Swick's[3] definition. The SPC compiles and evaluates descriptive comments from course/clerkship directors, clinical preceptors, and other faculty/staff, such that citations for deficiencies are issued by consensus. Prior studies have shown that similar descriptive/qualitative methods of evaluation can achieve a level of validity and reliability that is sufficient for high-stakes decisions.[16,17] Examples of behaviors that would be deemed unprofessional or lacking in self-awareness or moral reasoning include chronic tardiness or unexcused absences from clinic or other required activities, incomplete assignments, plagiarizing notes in the electronic medical record, or using disrespectful language toward or about a patient. The SPC evaluates all information pertinent to a case and renders a decision about remediation.[13] SPC decisions are guided by past precedents to ensure that citations are consistent across similar circumstances.

Study population and sample

Our study population consisted of all medical students who matriculated at IUSM between 2001 and 2009 (N = 2,700). All students included in our study had graduated or were otherwise no longer students at IUSM at the time the data were collected. The case group included all students who had appeared before the SPC for competency deficiencies related to professionalism at any point during medical school. The students in the control group were randomly selected from the entire population of students who had no SPC history. We determined that a total sample size of 300 students was needed to achieve adequate statistical power.[18]

Assessment of reflective ability

The primary source for determining students' reflective ability was the professionalism journal entries they submitted during their eight-week IM clerkship. Students were asked to reflect on an experience during the clerkship that taught them something about professionalism, taking into account whether the behavior or action they observed was effective, how they might have responded in a similar situation, and what they learned from the experience. The IM clerkship director granted us permission to use these journal entries on the condition that no current students were included in the study. Prior to any data analysis, we deidentified all journal entries and assigned each an ID number to allow us to later match the journal entries back to a case or control student.

We measured students' reflective ability using a validated scoring rubric[19] that incorporated components of reflection from the models described by Boud and colleagues,[20] Mezirow,[9,21] and Schön.[5] The rubric we used included seven levels of reflection (see Table 1). We selected this rubric because the scoring criteria were based on the most widely accepted theories of the reflective process and because its validity has been confirmed by several studies.[22–25] We obtained permission from one of the rubric's authors to use it in this study.[26]

Rater training and reflection scoring

Two authors (L.A.H., R.L.S.) were trained by one of the rubric's authors according to its published guidelines.[19] Those two authors scored 5 journal entries together, followed by 10 entries independently, at which point we calculated interrater reliability (IRR) using Cohen weighted kappa.[27] A weighted kappa measurement was selected for this study to allow for scaled degrees of agreement, such that a small discrepancy in scoring received greater weight than a large discrepancy.

Once we achieved an IRR of at least 0.8, one of the raters (L.A.H.) scored 559 journal entries written by the 300 students in the sample. If a student submitted multiple journal entries, only the first two entries (as determined by entry date and timestamp) were scored. To ensure reliability, and to prevent drift and decay from the rubric criteria, we assessed IRR after every 65 entries were scored. The secondary rater (R.L.S.) scored the last 15 entries, and we once again calculated IRR. Of the 559 journal entries, 135 were scored by both raters, and overall IRR was 0.84. The distribution of reflection scores is presented in Table 2.

Table 1

Levels of Reflection Measured by the Reflective Ability Rubric[a] Used in a Study of Medical Students' Reflective Ability and Professionalism Lapses, Indiana University School of Medicine, 2001 to 2009

Level	Reflection performance
0	Does not respond to the assignment
1	Describes procedure/case/setting without mention of lessons learned
2	States opinions about lessons learned without supporting examples
3	Provides superficial justification of lessons learned citing only one's own perspective
4	Offers reasoned discussion well supported by examples regarding challenges, techniques, and lessons learned, includes obtaining feedback from others or other sources
5	Analyzes the influence of past experience on current behavior
6	Integrates all of the above to draw conclusions about learning, provides strategies for future learning or behavior, and indicates evidence for determining the effectiveness of those strategies

[a]Source: O'Sullivan PS, Aronson L, Chittenden E, Niehaus B, Learman LA. Reflective ability rubric and user guide. MedEdPORTAL. 2010. https://www.mededportal.org/publication/8133.[19] Used in this study with permission.[26]

Table 2

Distribution of Reflection Scores in a Study of Medical Students' Reflective Ability and Professionalism Lapses, Indiana University School of Medicine, 2001 to 2009

Score[a]	Control group, no. (%)	Case group, no. (%)	Total
0	2 (0.9)	1 (1.4)	3
0.5	0 (0)	2 (2.9)	2
1	10 (4.3)	9 (12.9)	19
1.5	14 (6.1)	3 (4.3)	17
2	22 (9.6)	13 (18.6)	35
2.5	37 (16.1)	13 (18.6)	50
3	87 (37.8)	15 (21.4)	102
3.5	34 (14.8)	8 (11.4)	42
4	17 (7.4)	5 (7.1)	22
4.5	6 (2.6)	0 (0)	6
5	1 (0.4)	0 (0)	1
5.5	0 (0)	0 (0)	0
6	0 (0)	1 (1.4)	1

[a]Half points were allowed according to the scoring guidelines.[19] A half point was awarded when the raters felt that the reflection exceeded the criteria for the lower level but did not quite meet the criteria for the higher level.

Statistical analysis

All statistical analyses were conducted using SPSS Version 22 (IBM Corp., Armonk, New York). In addition to calculating reflection scores, we also examined the gender distribution and average age at matriculation for students in the case and control groups. We included gender because a previous analysis at IUSM found that males were significantly more likely to have been cited for competency-related deficiencies.[14] We included age at matriculation because a recent study found that students aged 31 or older were significantly more likely to have academic difficulties in medical school,[28] and we were interested in whether this group of students had been cited for professionalism deficiencies as well. We conducted *t* tests using independent samples to compare reflection scores and average age at matriculation between the two groups. If a student had two scored journal entries, we included only the higher score in the statistical analysis. The distribution of students' ages at matriculation was highly skewed, so we used a log transformation to achieve a normal distribution required to conduct a *t* test. We compared the gender distribution in the two groups using Pearson chi-square.

We used logistic regression analysis to examine the relationship between reflective ability and professionalism lapses. The dependent variable was whether or not a student had been cited for a professionalism deficiency during medical school. The independent variables were the student's (1) gender, (2) age at matriculation, and (3) reflection score. All independent variables were entered into the model in one step.

The Indiana University institutional review board deemed the research protocol exempt from full board review.

Results

Ninety-two students from the study population had been cited for competency deficiencies related to professionalism; however, 22 of these students did not have a professionalism journal entry for us to score and thus were excluded from the study. The remaining 70 students composed the case group. The control group included 230 randomly selected students who had no SPC history but at least one journal entry for us to score. Characteristics of the two groups are summarized in Table 3. The average age at matriculation and gender distribution of the control group were not significantly different from those of the overall student population at IUSM during the study period.[14]

Results of the *t* tests are presented in Table 3. Students in the case group had significantly lower reflection scores than students in the control group (case group = 2.46 ± 1.05 versus control group = 2.82 ± 0.83; P = .01).

Logistic regression analysis revealed that reflection score was significantly associated with professionalism lapses among the medical students in our sample. In the regression model, reflection score was considered a continuous variable, with values ranging from 0 to 6; therefore, the odds ratio indicates the change in the likelihood that a student had been cited for a professionalism lapse that would result from a one-point increase in reflection score. An odds ratio of less than 1 indicates a decreased likelihood, while an odds ratio of greater than 1 indicates an increased likelihood. The odds ratio for reflection score was 0.64 (95% confidence interval [CI]: 0.47–0.87; P < .01; see Table 4), which indicates that as a student's reflection score increased, the odds that she or he had been cited for a professionalism lapse decreased. Consequently, students who had lower reflection scores were more likely to have been cited for professionalism lapses. This increase in likelihood of having been cited for a professionalism lapse can be expressed by the inverse of the odds ratio (1/0.64 = 1.56; 95% CI: 1.15–2.13). Thus, for every 1-point decrease in reflection score, a student was 1.5 times more likely to have been cited for a professionalism lapse during medical school. Neither gender nor age at matriculation was associated with likelihood of having been cited for a professionalism lapse.

Discussion

Current literature supports that reflective ability is an essential component of professionalism.[2–4,8] A lack of reflection among practitioners has been cited as a potential cause for some lapses in professionalism.[29] Our study provides empirical evidence to support these claims by showing that lower reflection scores are associated with an increased likelihood of having been cited for a professionalism lapse during medical school. Although the difference in reflection scores between the two groups in our study was small, the higher scores in the control group suggest that those students considered the justification or evidence of their learning (based on the rubric's criteria), even if that evidence was based solely on their own personal opinion. The slightly lower scores in the case group suggest that those students accepted at face value what they

Table 3

Comparison of the Characteristics of the Control and Case Groups in a Study of Medical Students' Reflective Ability and Professionalism Lapses, Indiana University School of Medicine, 2001 to 2009

Characteristic	Control group (n = 230)	Case group (n = 70)	P value	Effect size[a]
Gender			.07	—
Male, no. (%)	132 (57.4)	49 (70.0)		
Female, no. (%)	98 (42.6)	21 (30.0)		
Age at matriculation			.06	—
Mean ± standard deviation	23.10±2.51	24.00±3.69		
Range	20–39	20–43		
Reflection score			.01	0.41
Mean ± standard deviation	2.82±0.83	2.46±1.05		

[a]Effect size was calculated using Cohen d.

were taught, without considering the evidence supporting it. We also should point out that the overall reflection scores in our study are consistent with those from previous studies using this rubric.[22–25]

Although the findings of this study point to an association between reflection and professionalism, the exact nature of this relationship is still unclear. A survey of IM clerkship directors revealed that most believed that reflection enhances students' professionalism, and thus they used reflective writing as a learning activity during their clerkship.[12] This notion is also the foundation of narrative medicine, in which physicians seek to understand patients' stories of illness to enhance their empathy, professionalism, and trustworthiness.[30] After participating in a narrative medicine elective, students perceived that engaging in reflection had helped their development both personally and professionally by increasing their capacity for empathy and for providing patient-centered care.[31] Such anecdotal claims aside, little empirical evidence supports the use of reflection as a tool to enhance professionalism, so further research is needed in this area.[32,33]

Others view reflection as a means for students to demonstrate their competence by providing evidence of their personal and professional growth and learning.[34] Prior studies of reflective writing largely have relied on qualitative methods to gain insights into students' professional attitudes and values[35,36]; however, these methods can be time consuming and subjective in nature. A quantitative approach could provide a more efficient and reliable method to assess professionalism; however, it first would require substantial evidence that reflective ability is a valid proxy measure for professionalism. This study provides some evidence to support this perspective, as students with higher reflection scores were also found to be "more professional" (as evidenced by their lack of citations for professionalism lapses). These findings are far from conclusive, but they provide a foundation for further research on this topic.

Limitations

This study has several limitations. First, it was conducted at a single institution; therefore, these findings may not be

generalizable to other medical schools. Second, the professionalism journals captured students' reflective ability at only one point in time; thus, it is unclear whether these journals are an accurate representation of the students' reflective abilities as we did not evaluate other writing samples to assess their reliability.

We also acknowledge that including self-awareness and moral reasoning as professionalism domains may have inflated the relationship between reflection and professionalism because these traits may be considered inherent in one's ability to reflect. However, our analysis of those students who were cited only for professionalism lapses (n = 57) yielded similar results.

Next, this study was retrospective and relied only on data that were available at the time of data collection; for example, 22 students did not have a professionalism journal entry to score and therefore were not included in our analysis. Inquiries to the student affairs office revealed that 8 of these students had been dismissed or withdrew from IUSM before completing their IM clerkship. We could not find an explanation for the remaining 14 students. Perhaps their failure to submit a professionalism journal entry reflects a cavalier attitude toward personal accountability, which contributed to their citation in the first place. We selected the control group from only those students who had submitted journal entries, so we do not know how many potential control group students did not submit journal entries or if this proportion differs from that of the case group.

The timing of the professionalism deficiency citations and remediation activities is another confounding factor, because students who are cited for professionalism lapses are often required to engage in reflective writing as part of their remediation.[37] If the citation occurred before the third-year IM clerkship, this exposure to reflective writing may have had some influence on students' reflective ability, which in turn affected their professionalism journal entries. As students in the case group still had significantly lower reflection scores, this factor likely did not affect the results of our study. Finally, we acknowledge that any number of other confounding factors, such as students' background or

Table 4

Results of a Logistic Regression Analysis of Predictor Variables in a Study of Medical Students' Reflective Ability and Professionalism Lapses, Indiana University School of Medicine, 2001 to 2009

Predictor	Odds ratio	95% confidence interval	P value
Gender (male)	1.74	0.97–3.13	.063
Age at matriculation	1.51	0.98–2.34	.061
Reflection score[a]	0.64	0.47–0.87	.004

[a]Reflection score was entered into the model as a continuous variable from 0 to 6.

personality characteristics, might have had some influence on their reflective ability and/or professionalism.

Conclusions

We found a significant association between medical students' reflective ability and their professionalism, although we cannot infer a causal relationship from our findings. Nonetheless, reflection appears to be a valuable addition to the medical curriculum, as a means of helping students develop professionalism and as a means by which students can demonstrate their professionalism. Another interpretation of our findings is that this is not a linear, causal relationship but, rather, a circular relationship in which one factor enhances the other. Regardless of their purpose, reflective activities must be effectively integrated into the curriculum, lest they be perceived as disconnected from the overall educational experience. For students to recognize the importance of reflection, activities must be accompanied by a culture that values reflection and aims to develop reflective practitioners.[8]

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Race-Conscious Professionalism and African American Representation in Academic Medicine

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Abstract

African Americans remain substantially less likely than other physicians to hold academic appointments. The roots of these disparities stem from different extrinsic and intrinsic forces that guide career development. Efforts to ameliorate African American underrepresentation in academic medicine have traditionally focused on modifying structural and extrinsic barriers through undergraduate and graduate outreach, diversity and inclusion initiatives at medical schools, and faculty development programs. Although essential, these initiatives fail to confront the unique intrinsic forces that shape career development.

America's ignoble history of violence, racism, and exclusion exposes African American physicians to distinct personal pressures and motivations that shape professional development and career goals. This article explores these intrinsic pressures with a focus on their historical roots; reviews evidence of their effect on physician development; and considers the implications of these trends for improving African American representation in academic medicine. The paradigm of "race-conscious professionalism" is used to understand the dual obligation encountered by many minority physicians not only to pursue excellence

in their field but also to leverage their professional stature to improve the well-being of their communities. Intrinsic motivations introduced by race-conscious professionalism complicate efforts to increase the representation of minorities in academic medicine. For many African American physicians, a desire to have their work focused on the community will be at odds with traditional paths to professional advancement. Specific policy options are discussed that would leverage race-conscious professionalism as a draw to a career in academic medicine, rather than a force that diverts commitment elsewhere.

Notwithstanding important progress, substantial challenges remain in ameliorating racial inequalities in health and health care in the United States. One enduring challenge is the underrepresentation of minority populations, especially African Americans, among the faculty at academic medical centers (AMCs). At each stage of career development, African Americans remain less likely than other physicians to hold academic appointments. Despite constituting 13% of the American population as of 2014, African Americans accounted for only 7.4% of assistant professors, 3.8% of associate professors, and 1.4% of professors at AMCs.[1] The statistics are even more troubling for African American males.[2] Such profound underrepresentation comes with substantial negative implications for our health care system, and the nation as a whole.[3]

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In this Perspective, we explore the intrinsic pressures that contribute to African American underrepresentation at AMCs with a focus on their historical roots; review evidence of their effect on physician career development; and consider the implications for AMCs seeking to improve African American representation among their faculties. We conclude by providing specific policy options.

Extrinsic Versus Intrinsic Forces in Shaping Career Development as Factors Contributing to Underrepresentation

Physician career development is shaped by both extrinsic (e.g., educational opportunities, role models, mentorship, financial support) and intrinsic (e.g., intellectual curiosity, community service, altruism) forces.[4] Structural impediments in the educational pipeline and training environment for African Americans are numerous—poor education and school quality; lack of role models; financial cost of education and training; and persistent bias, stereotyping, and racism—and impact substantially the extrinsic forces shaping career development.[2,5,6] Efforts to ameliorate African American underrepresentation in academic

medicine have traditionally been focused on modifying these extrinsic forces through tactics such as undergraduate and graduate outreach, diversity and inclusion initiatives at medical schools, and faculty development programs.

Although these are essential programs, we believe the prevailing focus on extrinsic factors has obscured the role intrinsic forces play on the decision to pursue and sustain a career in academic medicine. America's ignoble history of violence, racism, and exclusion exposes African American physicians to distinct personal pressures and motivations that shape their professional development and career goals. Whereas similar forces undoubtedly shape career development for other marginalized populations across the lines of race, class, gender, and sexual orientation, the historical specifics of the African American experience render this manifestation unique.

Race-Conscious Professionalism and Intrinsic Motivation

The exceptional nature of the African American experience in the professional realm is not a novel observation. Harvard law professor David B. Wilkins[7] has used

the term "race-conscious professionalism" to describe the process black professionals confront when attempting to "navigate the competing demands of professionalism, racial obligations, and personal integrity." Amidst a history of oppression and continued racial injustice, many African American professionals are acutely aware of the implications of their success on racial politics and the well-being of their broader communities. For many, this results in a dual obligation: to achieve professional excellence while working to improve their communities.[8]

Race-conscious professionalism has been an enduring component of the African American experience in medical practice.[9] This began as early as the 1840s, when many of the nation's first formally educated African American physicians used their positions as community leaders and their scientific credibility to challenge the institution of slavery. After the Civil War, African American physicians built medical schools and hospitals that served not only as a way to care for the African American community but also as conduits to build an African American professional class. The existence of race-conscious professionalism continued in the 20th century, when African American physicians assumed leadership roles in fights against segregation within and outside of the medical profession. African American physician–activists were instrumental leaders in catalyzing reforms such as the Civil Rights Acts, hospital desegregation rulings, the Voting Rights Act, and Medicare/Medicaid legislation.[9] For nearly two centuries, African American physicians have used their professional training, and the expertise and stature it affords, to address the contemporary challenges facing their communities.

Understanding the historical precedents of race-conscious professionalism can help clarify the intrinsic forces that African American physicians face in developing their professional identity. Just as the struggles of slavery and segregation drew the involvement of peers from previous eras, today's African American physicians practice in an environment where they are continually reminded of persistent racial disparities. Most have experienced or witnessed, firsthand, inequalities in the access to, and quality of, health care. These realities are not limited to health care, as evidenced by the

recent #BlackLivesMatter campaign and protests at many U.S. medical schools.[10] A consistent subtext of disparities and injustice continually reinforces the dual obligations of race-conscious professionalism and, in doing so, shapes professional development. In this climate, African Americans often find themselves not only concerned with clinical excellence and professional advancement but also focused on how their career can most positively impact their community.

Empirical evidence supports the role of race-conscious professionalism in shaping career decisions. Resolving the dual obligations to self and community can be accomplished, in part, by choosing careers aimed at caring for minority populations. African American physicians have assumed a central role in caring for minority communities and working to ameliorate racial disparities in health and health care outcomes.[9] African American patients are a staggering 23 times more likely to have an African American physician than a white physician.[11] Similar research has found that African American primary care physicians are roughly 40 times more likely than white physicians to care for African American patients.[12] Finally, researchers have found that African American physicians are more likely to seek out, and remain, in areas where they can care for minority populations.[13]

Implications for AMCs

Intrinsic motivations introduced by race-conscious professionalism complicate efforts to increase the representation of minorities in academic medicine. Even if extrinsic barriers to advancement are removed, underrepresentation is likely to persist. For many African American physicians, a desire to have their work focused on the community will be at odds with the experiences and outputs required under traditional paths to professional advancement at AMCs. For example, most minority faculty members responding to a large national survey reported that their own values were poorly aligned with those of their institution.[14] To counter these trends, there are several strategies that AMCs can employ to leverage race-conscious professionalism in efforts to recruit and retain African American faculty. Doing so will require new opportunities for advancement that lie

outside of traditional realms of basic science and clinical research, which is the predominant path to advancement and the one most conflicting with intrinsic motivations for many African American physicians.

Within the context of patient care, AMCs could more proactively and explicitly establish themselves as centers for excellence in caring for underserved and minority populations. Many AMCs serve a critical role in caring for underserved patients, and the potential for innovation around how to do so most effectively and efficiently could be a draw for many African American physicians motivated by race-conscious professionalism. For example, the Johns Hopkins University School of Medicine established the Urban Health Institute, focused on improving the health and well-being of the East Baltimore community through research, engagement, and patient care.[15] Within the realm of research, AMCs could establish research centers dedicated to health and health care issues facing African American communities. The Disparities Solution Center at Massachusetts General Hospital coordinates and conducts a broad portfolio of research activities related to minority health that engage research faculty across the nation. And within the realm of education, AMCs can continue to develop programs aimed at the successful recruitment and training of African American physicians. Opportunities for teaching and mentoring the next generation of African American physicians are likely to be significant draws for junior and senior faculty members alike.

AMC leaders should consider establishing centers or institutes dedicated to minority health care disparities that can serve as a locus for these and related activities. Beyond serving an important coordinating function, these structures also act as a signal to faculty members about the values and priorities of the institution. Many AMCs have already taken important steps in establishing such bodies, and it will be important to evaluate the extent to which they promote the retention of African American faculty.

Finally, AMCs should make an explicit commitment to valuing the contributions of physicians working to ameliorate health care disparities and racial injustice.

Recently, clinical, education, and health systems innovation paths for tenure have emerged alongside the traditional tracks of biomedical and clinical research.[16] By giving faculty credit for the advancement of social justice and the reduction of health disparities within the communities they serve, AMCs can improve faculty retention and communicate the value of these activities.

In addition to AMC leadership, other stakeholders have an important role to play in accelerating necessary change. Funding from federal grant-making bodies such as the National Institute of Minority Health and the Health Resources and Services Administration, as well as private foundations, can help support the research and clinical care activities described above. More active engagement and participation of community board members and patient advisory boards could help direct AMC attention to this area. Finally, local and state legislative activity has been used to incorporate the issue of underrepresented minorities in the health professions into regulatory frameworks.[17]

Concluding Remarks

There remains a dire need for more African Americans in teaching, research, and leadership positions at AMCs. Achieving this goal will provide role models, mentors, and diversity input into the research, innovation, education, and care delivery missions of AMCs. Careers in academic medicine have tremendous potential for African American physicians to reconcile the dual obligations of race-conscious professionalism through publishing, teaching, research, and influencing students, mentees, colleagues, and other leaders. To be successful, programs and initiatives aimed at addressing the continued underrepresentation of African Americans at AMCs must entertain and address the intrinsic, personal, and intimate realities of the African American experience in medicine. In doing so, race-conscious professionalism will become a draw to a career in academic medicine, rather than a force that diverts commitment elsewhere.

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Parting the Clouds: Three Professionalism Frameworks in Medical Education

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Abstract

Current controversies in medical education associated with professionalism, including disagreements about curriculum, pedagogy, and assessment, are rooted in part in the differing frameworks that are used to address professionalism. Three dominant frameworks, which have evolved in the medical education community, are described. The oldest framework is virtue based and focuses on the inner habits of the heart, the development of moral character and reasoning, plus humanistic qualities of caring and compassion: The good physician is a person of character.

The second framework is behavior based, which emphasizes milestones, competencies, and measurement of observable behaviors: The good physician is a person who consistently demonstrates competence in performing patient care tasks. The third framework is identity formation, with a focus on identity development and socialization into a community of practice: The good physician integrates into his or her identity a set of values and dispositions consonant with the physician community and aspires to a professional identity reflected in the very best physicians. Although each

professionalism framework is useful and valid, the field of medical education is currently engaged in several different discourses resulting in misunderstanding and differing recommendations for strategies to facilitate professionalism. In this article, the assumptions and contributions of each framework are described to provide greater insight into the nature of professionalism. By examining each discourse in detail, underlying commonalities and differences can be highlighted to assist educators in more effectively creating professionalism curricula, pedagogy, and assessment.

When the topic of professionalism arises, the clouds of confusion descend, making it difficult to see the landscape: "There seems to be no agreement on what the term [i.e. professionalism] means."[1] For some, professionalism refers to virtues, aspirations, and humanism embodied in the good physician.[2,3] Within this framework, virtuous physicians are able to apply ethical reasoning, restrain self-interest to their actions, and demonstrate compassion and respect as a humane person. Another perspective asserts that professionalism is a set of behaviors, a competency or a role that physicians perform.[4,5] Professionalism within this definition is a domain of competence to be mastered, demonstrated, and assessed. Another framework defines professionalism as identity formation,[6–8] which is a developmental process that

describes how physicians in training take on increasing levels of professional identity. It involves being socialized into thinking, acting, and feeling like a professional. Unfortunately, much of the conversation and associated debates on professionalism fail to recognize the differing underlying frameworks, assumptions, and discourse communities, which results in misunderstanding and confusion.[9]

Historically, conceptions of professionalism have been modified or created anew to address the perceived shortcomings of the extant approaches to producing the good physician. For example, the virtues-based/ethics approach was used implicitly for generations but made more explicit in response to the increasingly complex ethical decisions created by new technologies and therapeutics, by the inability to imbue trainees with physician virtues through role models alone, and by patient complaints about uncommunicative and uncaring physicians. The behavior-based competency movement, with its focus on performance outcomes, arose out of frustrations with subjective measures of character and the apparent failure of trainees and physicians to apply moral reasoning to their subsequent actions. In turn, identity formation

developed in reaction to the perceived reductionistic and prescriptive behavioral approach to competencies and milestones. Although advocates for these three frameworks often contest with one another over assumptions and recommendations, we feel that they are often talking past each other.

In this article, we describe three dominant frameworks that describe professionalism. Our approach is to examine professionalism from a variety of contrasting viewpoints to deepen our conceptual understanding of this complex construct. We examine the assumptions made by each framework and highlight both the historical and theoretical contexts that led to the crystallization of these assumptions. Our analysis suggests that no one framework is adequate for describing professionalism and that, in considering the features of each framework in turn, or as part of a whole, we gain a deeper understanding of the term.[10] In this article, we seek to clarify the construct of professionalism and describe various strategies for curriculum, pedagogy, and assessment that are suggested by each framework and conclude by discussing their respective contributions. See Table 1 for a comparison of the three professionalism frameworks.

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Table 1

Comparison of Three Professionalism Frameworks: Their Focus, Assumptions, Strengths, and Recommendations

Framework	Focus	Assumptions	Strengths	Recommendations
Virtue-based professionalism	Moral character, moral reasoning, and humanism	Appropriate action is a result of internalizing the right values and ethical principles until habits are created	Places internal values and motivation first and routinizes moral reasoning	Internalize and gain commitment to a core set of values and actions that are guided by moral reasoning
Behavior-based professionalism	Behaviors, milestones, and competencies	Appropriate actions are a result of clear expectations, feedback on performance, and reinforcement from external stimuli	Clarifies expectations, provides directive feedback, and evaluates and certifies competence	Clarify expectations, teach to behaviors, provide feedback, reinforce correct behavior, and sanction unprofessional behavior
Professional identity formation	Evolving and changing identities	Appropriate action results from the development of a professional identity by socialization into a community of practice	Describes the developmental trajectories of identity formation and socialization	Provide positive role models and sensitize learners in advance to situations in which they might encounter negative role models

Virtue-Based Professionalism

Construct

The virtue-based framework is the oldest, going back to Hippocrates, and continues to evolve and have strong advocates today.[3,11,12] In the early 20th century, the physician was viewed as a man of character, whereas in the 21st century the physician is viewed as someone with characteristics, such as competence.[13] In the virtue-based framework, physicians are viewed as moral agents who must put aside self-interest to act in the best interest of their patients. Virtuous physicians are expected to place the needs of patients before their own, keep information confidential, disclose and deal with conflicts of interest, and be altruistic, honest, reliable, and respectful. Virtue-based professionalism focuses on the internal habits of the heart, moral values, moral reasoning, and character development. Physicians are expected to apply ethical principles to their decisions and actions—ethical principles such as autonomy, beneficence, nonmaleficence, and justice. Many of these ethical principles have been codified into rules that must be learned and followed, such as informed consent, disclosing conflicts of interest, and ensuring confidentiality of patient information.

From this perspective, professionalism requires compliance with these rules and expectations. This is often referred to as the medical profession's social contract with society.[14] In developing understanding of these rules and expectations, medical students progress or fail to progress through predictable stages in their moral development and moral reasoning.[15–19] This stage model has been applied to remediation of medical students with arrested moral development as demonstrated by professionalism lapses.[20]

Humanism is often associated with this framework, being concerned with compassion, respect, and effective communication with patients. The intent of virtue-based professionalism and humanism is to internalize values and ethical reasoning to develop a self-giving disposition toward patients and colleagues. In this framework, professionalism is the application of virtue to practice.[3]

Strategies

Writers who use a virtue-based framework make recommendations for curricular, pedagogical, and assessment strategies to facilitate learning. Professionalism is often a theme that runs throughout the curriculum, and includes medical ethics,

moral reasoning, humanism, patient communication, and often the use of honor codes. One example of such an honor code comes from the University of Texas Medical Branch (UTMB) at Galveston, where all employees and learners must pledge: "On my honor, as a member of the UTMB community, I pledge to act with integrity, compassion, and respect in all my academic and professional endeavors."[21] Rituals such as the white coat ceremony are also used to instill professional values. Pedagogical strategies include the use of direct instruction, the Hippocratic Oath, role models, case studies, reflective writing, appreciative inquiry, and white coat ceremonies.[22] Assessment is typically carried out through written exams, reflective writing exercises, self-assessment, observations and feedback, and, sometimes, moral reasoning assessment.

Remediation

Professionalism lapses are viewed as a failure of character and virtue.[3] Lapses can also be seen as a failure to move through the predictable stages of moral development, which involves incorporating professional values and the practical wisdom to discern how to respond to given situations. When professionalism lapses occur, they should be dealt with by seeking to understand what prompted the behavior, encouraging the learner to reflect on the aspirational goals of professionalism and their own behavior, and developing their moral reasoning abilities.[20]

The virtue-based approach to professionalism focuses on inner habits of the heart, the development of moral character, and acting in a self-giving, ethical, caring, and humanistic manner. Because this framework promotes adoption of aspirations and inner dispositions, learners often report feeling less coerced and more inspired than when confronted with the behavioral approach.[3] The dominant assumption of this framework is that professionalism involves altruism and self-sacrifice, where the good doctor is a person of character.[12,23]

Behavior-Based Professionalism

Construct

The dominant framework for professionalism today is behavior or outcome based, which focuses on competencies

and emerged out of frustrations associated with attempting to measure and evaluate character as described by the virtue-based framework. Behaviors can be defined, observed, and assessed—thus allowing complex and integrated sets of competencies to be demonstrated and certified. For almost two decades, the Accreditation Council for Graduate Medical Education (ACGME), the American Board of Internal Medicine, the Royal College of Physicians and Surgeons of Canada, and the General Medical Council in the United Kingdom have all subscribed to an outcomes-oriented learning model that is anchored in competencies.[24–26] As an example, the ACGME refers to professionalism as one of six domains of competence; in the ACGME's framework, professionalism includes demonstrating compassion, integrity, and respect; being responsive to patient needs; and being accountable to patients, society, and the profession. More recently, the Carnegie Foundation for the Advancement of Teaching endorsed this framework by calling for standardization of learning outcomes and individualization of the learning process.[6]

Milestones are the developmental steps toward full competence, which can be clearly defined and monitored to assess resident and fellow progression. Professionalism milestones make explicit reference to an increasingly sophisticated set of behaviors that include caring, honesty, and a commitment to patients and their families, all the way up to managing ethical conflicts and demonstrating leadership regarding the principles of bioethics.

An emerging elaboration on the behavioral framework is the addition of a systems perspective. Advocates of this persuasion make the argument that many professionalism issues arise out of conflicting expectations and clashes that inevitably follow boundary-spanning interactions in complex organizations. Conflicts can occur when performing a handoff, seeking a consult, admitting a patient to an inpatient service, and discharging a patient. Systems can precipitate or mitigate professionalism lapses. To act in a professional manner, learners require knowledge, skill, and judgment to deal with specific situations and to negotiate conflicts.[27]

Strategies

Curriculum strategies involving this framework include teaching learners the expected behaviors and competencies as well as systems thinking, root cause analysis, diplomacy, and communication, especially in crisis situations. Pedagogical strategies include direct instruction, role modeling, case studies, simulations, peer and instructor coaching, as well as written examinations and reflections on self-awareness and self-control in conflict-prone settings. Assessment often involves the use of written exams, rating forms, self-assessment, observations and multisource feedback, critical incident reports on lapses, and professionalism mini observations.[27,28]

Remediation

Professionalism lapses are viewed as acts of inappropriate behavior and reflect a lack of skill in negotiating conflict-prone situations. The most common professionalism lapses are (1) lapses in responsibility (e.g., late or absent, unreliable), (2) lapses related to the health care environment (e.g., cheating, falsifying data, disrespecting other members of the team), (3) lapses related to diminished capacity for self-improvement (e.g., arrogance, defensiveness), and (4) lapses around impaired relationships with patients (e.g., poor rapport).[29] Remediation strategies often involve a system to identify lapses, meeting with the student when a lapse is observed, developing a remediation plan, and monitoring compliance with the plan.[30] Other frequently used strategies for remediation include mandated mental health evaluation/treatment, completion of a professionalism assignment, mandated professionalism mentor, and counseling for stress or anger management.[31] Lucey[32] makes the case for continuous formative evaluation of professionalism by using root cause analysis to identify and debrief professionalism lapses. All students should be taught the skills to skillfully manage even the most challenging professionalism situations.[27,32]

This framework also asserts that professionalism issues arise at three levels: with the individual physician and patients, with colleagues, and with society. In addition to physician–patient interactions, professionalism issues arise during interactions with other members of a practice, clinic, or hospital, and with the external environment. The latter include payers, policy makers, and systems that perpetuate inequities in health care. Each of these levels of professionalism interacts with the others and requires different lenses for determining appropriate forms of professional action.[5,9]

The behavior-based competency framework emphasizes the importance of clarifying learning outcomes and of teaching to and examining observable behaviors. The focus is on doing rather than being. The systems perspective adds clarity to the context within which professionalism is lived out. The dominant assumption in this framework is that professionalism involves measurable behaviors, and that the good doctor is one who is competent in performing various patient care tasks.

Professional Identity Formation

Construct

The third framework is professional identity formation, which has received considerable attention in recent years as medical educators responded to the limitations of the behavior-based framework.[8,33–35] Identity addresses who we are and who we want to become. This involves the evolution of one's identity with an increasingly integrated commitment to the values, dispositions, and aspirations of the physician community. Identity formation is viewed as an adaptive, developmental process occurring at individual (psychological)[8,36] and collective (sociological)[37] levels that socialize learners into thinking, feeling, and acting like a physician.[8] Learning evolves through participation in a community of practice, through observation of role models and their interactions with others, as well as direct instruction, coaching, assessment, and feedback.[6,7]

Strategies

Identity formation can be addressed as a curricular theme within doctoring and ethics courses. These curricular themes tend to be learner focused and developmental in nature. Examples of developmental challenges in identity formation include the early transition from being a graduate student to a physician in training, from being a student in the classroom to a member of a health care team in a clinical setting,

and from being a learner with minimal responsibility to a resident with major responsibility for patient care. Questions that arise for students and residents include *How do I fit into this team and/or profession? How do I see myself in this context? Do I identify with members of this community of practice? Do I aspire to be like them?*[38–40]

Pedagogical strategies include direct instruction, role models, case studies, guided discussion of emerging and often conflicting identities, use of self-assessment, reflective writing, and appreciative inquiry.[14,22] Assessment is usually multidimensional and multisource and uses aspirational orientations toward assessment and, sometimes, moral reasoning assignments and assessment.[7,8,16]

Remediation

Professionalism lapses are viewed as a failure to progress through the developmental stages of identity formation and internalize the values of the medical profession. This requires stage-appropriate strategies to monitor and intervene when lapses occur. Remediation programs need to be tailored to the developmental stage of the learner and assist the learner to understand the nature of professional identity, the process of formation, and the obligations inherent in becoming a physician.[7] Measures of moral reasoning, use of a professionalism identity essay, along with self-assessment and reflection have been successfully used to remediate professionalism lapses.[20]

Professional identity formation focuses on both the individual and the group and, like the virtue-based framework, explores internal developmental processes of being and becoming versus doing. The dominant assumption in this framework is that professionalism involves becoming a good doctor by aspiring to attain a certain professional identity, as depicted by positive role models. This perspective goes beyond the virtue- and behavior-based frameworks by acknowledging the powerful social forces implicit in becoming part of a community of practice.[29]

Reflections

Each framework has strengths and limitations and contributes to the larger whole. The strength of the

virtue-based framework is its emphasis on character—the inner life of the physician, aspirations, moral reasoning, and habits of the heart. This perspective helps to motivate and inspire learners and removes much of the perceived bludgeoning effect of the behavioral framework. The challenge with this framework is that it is difficult to assess character and moral reasoning, although Bebeau and Lewis's[16] work on assessing moral reasoning suggests that this is possible.

The strength of the behavior-based framework is its clarity of expectations and connection to assessment.[27,28,41,42] Articulators of this framework have thought the most deeply about issues of assessment and remediation.[27,28,41–43] This framework also goes beyond the level of the individual professional and the patient to include interactions with colleagues, the profession, and health policy. However, this framework is often criticized for its reductionistic approach, which tends to separate different components of integrated actions into discrete behaviors, which, in turn, creates unrealistic demands

on assessment and feedback. This is partially being addressed through the use of entrustable professional activities, which aggregate competencies into larger and more integrated tasks/activities.[44,45] Finally, the behavior approach assumes that behaviors accurately reflect inner mental models and, as such, can be meaningfully assessed.

Professional identity formation calls attention to both the person and the group and explores developmental processes of being and becoming. This framework is more difficult to describe, interpret, and assess, although recent work within this framework is beginning to flesh this out. More research on the implementation and effectiveness of recommendations arising from this framework, as well as the other two, is needed and will help guide future practice.

While proponents of these three frameworks base their recommendations for curriculum, pedagogy, and assessment on differing assumptions, their recommendations both diverge and converge. See Table 2 for practical applications of

Table 2
Practical Applications of Three Professionalism Frameworks on Curriculum, Pedagogy, and Assessment

Strategies	Virtue-based professionalism	Behavior-based professionalism	Professional identity formation
Curriculum	Ethics and moral development, patient communication, humanism, honor codes	Competencies, systems thinking, diplomacy and crisis communication	Stages of identity formation and development, values, ethics
Pedagogy	Direct instruction, role models, case studies, reflective writing, guided discussion, appreciative inquiry, white coat ceremonies	Direct instruction, role models, case studies, coaching, simulations, reflection on action	Direct instruction, role models, case studies, reflective writing, guided discussion, appreciative inquiry
Assessment	Written exams, self-assessment, observations and feedback, moral reasoning assessments	Written exams, self-assessment, observations and feedback, performance assessment, rating forms, multisource feedback, critical incident reports on lapses, professionalism mini observations	Self-assessment, multisource feedback using aspirational frameworks, moral reasoning assessments

the three frameworks on curriculum, pedagogy, and assessment.

Professionalism lapses are viewed differently by the three frameworks (i.e., lapse of character, lapse of behavior, lapse of identity formation), yet they share common remediation strategies: Feedback needs to be formative rather than punitive, individuals and systems need to be held accountable, interventions should involve self-reflection and skill development, remediation plans and future actions should be monitored, and consequences should escalate in a stepwise fashion that is appropriate to the specific lapse.[46]

By contrasting these frameworks, the distinction between *professionalism as a trait* (character or behavior) and *professionalization as a process* (identity formation and development) becomes more sharply visible. We can see that *professionalism* involves attributes of the individual, such as behaviors, skills, or attitudes that lead to decisions that reflect distinguishing features of the profession. In the case of medicine, these would include putting patients' needs above the self and exhibiting responsibility for the patient in terms of confidentiality, conflicts of interest, honesty, reliability, and respect. *Professionalization*, on the other hand, is concerned with the process of becoming a member of a profession. This includes processes of socialization and identity formation—in other words, taking on the features of a professional who defines that specific community. This includes the process of taking on professional values, which might then result in a demonstration of professionalism.

Becoming a good doctor is consonant with each framework. Although we have represented these three frameworks as pure types, the edges are often fuzzy, and some authors have moved among them. For example, the works of Bebeau et al and the Cruesses and colleagues have addressed professionalism from the perspective of virtues/ethics[14,15] as well as identity formation.[7,8,16,20]

From our perspective, current conflicts in medical education over curriculum, pedagogy, and assessment of professionalism are rooted in the differing assumptions underlying each framework. By better understanding them, we hope that the conversations and dialogue around professionalism can be clarified and made more transparent to teachers and learners alike.

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A Framework for Understanding Lapses in Professionalism Among Medical Students: Applying the Theory of Planned Behavior to Fitness to Practice Cases

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Abstract

Fitness to practice decisions are often based on a student's digression from the regulations, with limited exploration of the reasoning behind the student's behavior. However, behavior is underpinned by complex, "hidden" variables, including an individual's attitudes and social norms. Examining hidden determinants of professionalism, such as context, interpersonal relationships, social norms, and local cultures, then allows medical educators to develop a richer understanding of unprofessional behavior.

In this article, the authors propose the use of the theory of planned behavior (TPB) as a framework to help evaluate unprofessional behavior in students. The TPB is a deliberative processing model that explains how an individual's behavior is underpinned by his or her cognitions, with behavior being primarily dependent on the intention to perform the behavior (*behavioral intention*). Intention, in turn, is determined by three variables: *attitude*, *subjective norm*, and *perceived behavioral control*.

To understand the practical use of the TPB, the authors present four complex, anonymized case studies in which they employed the TPB to help deal with serious professionalism lapses among medical students. The outcomes of these cases as well as the student and program director perspectives, all explained via the TPB variables, are presented. The strengths and limitations of the TPB are discussed.

Internationally, regulatory bodies dictate that graduating medical students' outcomes move beyond acquisition of knowledge and skills to include appropriate professional attitudes and behaviors,[1–5] requiring students not just to behave professionally but also to become professional.[6–8] The importance of recognizing lapses in professionalism early is borne out by studies showing that unprofessional behavior by medical students predicts subsequent misconduct.[9–13] Consequently, teaching and assessing professionalism is gaining momentum globally,[14–17] with approaches varying among nations from consensus statements (e.g., United States and Canada)[5,18] to medical student licensure

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(e.g., Australia).[19,20] In the United Kingdom, the General Medical Council (GMC) provides guidance regarding sanctions for unprofessional behavior[21]; however, the use of this guidance is at the discretion of individual medical schools.

Numerous theoretical approaches have been adopted to study medical professionalism. A values, ethics, and morality approach positions professionalism as a product of an individual's ethical and moral standards; his or her humanistic qualities, including integrity and honesty; and his or her attributes, such as altruism and accountability.[22–24] A professional identity formation approach adopts the notion that feeling like a part of the medical community facilitates individuals becoming professional and ethical practitioners,[25,26] a theory supported by Hilton and Slotnick's[6] description of professionalism. A sociological perspective defines professionalism as a social contract requiring doctors to behave professionally to justify the trust that society places in them.[27] Finally, sociocognitive psychology uses the complex relationship between attitudes and behavior to explain professionalism lapses.[28,29]

When a student's fitness to practice (FTP) is called into question, educators undertake a complex decision-making process: collecting evidence, evaluating the nature and severity of the misconduct, and deciding whether to refer the student to an FTP panel. FTP panels make decisions based on the evidence, with students who are in breach of professional behavior being subject to sanctions ranging from formal warnings to expulsion from the program. Often these decisions are based on the student's digression from the regulations, with limited exploration of the reasoning behind the student's behavior.[30–32] However, behavior is underpinned by complex, "hidden" variables, including an individual's attitudes and social norms.[33] Examining hidden determinants of professionalism, such as context,[34,35] interpersonal relationships, social norms, and local cultures,[36–38] then allows us to develop a richer understanding of unprofessional behavior.[29,36]

Given this, there is a need for a theoretically driven framework to facilitate decision making among staff involved in FTP procedures. We propose the use of the theory of planned behavior (TPB) to help evaluate unprofessional behavior in students, which two of us (V.J., T.R.) have used in our own practice to study such behaviors and discuss possible reasons for them.

The TPB

The TPB[33] is widely used for studying behaviors in individuals[39,40] including health care providers' behaviors.[41] It is a deliberative processing model that explains how an individual's behavior is underpinned by his or her cognitions, with behavior being primarily dependent on the intention to perform the behavior (*behavioral intention*). The relationship between intention and actual behavior is not absolute, but intention may act as a proximal determinant of behavior.[42] Intention, in turn, is determined by three variables: *attitude*, *subjective norm*, and *perceived behavioral control* (Figure 1).

Attitude reflects the degree to which an individual positively or negatively evaluates a behavior or favors performing the behavior. The evaluation comprises instrumental (is the behavior good or bad, desirable or undesirable) and experiential (is the behavior pleasant or unpleasant, useful or worthless) aspects. Attitude is a function of *behavioral beliefs* (performing the behavior will lead to consequences) and *outcome beliefs* (evaluation of those consequences).

The subjective norm comprises the degree of social pressure on an individual to engage in a behavior[41] and the degree to which salient people in the individual's life (such as family, friends, faculty) would approve or disapprove of the behavior. The subjective norm may be injunctive (what salient people in the individual's life think ought to be done) or descriptive (what salient people in the individual's life actually do). The subjective norm is a function of *normative beliefs* (perceptions of salient others' preferences about the behavior) and *motivation to comply* (the extent to which one wishes to comply with salient others' expectations).

Perceived behavioral control reflects an individual's perceptions of how easy or difficult it is to perform the behavior[43] and the individual's self-efficacy and control over the behavior. Perceived behavioral control is a function of *control beliefs* (whether one has the opportunity to perform the behavior successfully) and *perceived power* (the perception that certain factors have the power to facilitate or inhibit the completion of the behavior). According to the TPB, the more favorable the attitude and subjective norm and the greater the perceived behavioral control, the stronger the individual's intention to perform the behavior will be.[33]

When examining professionalism, the TPB presents a unified approach,[28,29] bringing together several influences on professionalism described earlier: attitudes, moral and ethical values, and contextual and social interactions. It explores both factors that are under the direct control of the individual (e.g., beliefs and response to social influences) and factors that are not (e.g., resources and opportunities to perform behaviors).[33]

Application of the TPB

To understand the practical use of the TPB, we present four complex, anonymized case studies in which we employed the TPB to help us deal with serious professionalism lapses among medical students. The outcomes of the cases as well as the student and program director perspectives, all explained via the TPB variables, are presented.

Case 1

Student A, a second-year medical student, is asked to visit a family with two disabled children as part of her community placement. She submits her logbook with this visit signed off by the children's mother and a reflective essay describing her visit. Later, the year lead is surprised when the mother calls and asks why the student has not come to visit.

At a meeting with the program director, the student immediately admits to falsifying the logbook, saying it was a terrible mistake. She says she is an excellent student and challenges the decision to reprimand her for her behavior, claiming "everyone in [her] class does this." After all, the students know that no one looks at the logbooks in detail.

Student's perspective. The student probably felt that by immediately admitting to her misconduct she would demonstrate an appropriate attitude toward her behavior and escape sanctions. Her perception that other students forged logbooks but were never caught made her behavior the subjective norm. She felt getting activities signed off was sometimes difficult, making forging the signatures an easier option (control beliefs). Additionally, the student suspected that the logbooks were not properly scrutinized, making her decision to forge the entries easier (perceived power).

Program director's perspective. The student confirmed the behavior and behavioral intention but demonstrated a limited ability to evaluate the consequences of (outcome beliefs) or consider how the medical school would view the behavior (normative beliefs). She failed to find the motivation to comply with GMC guidance.

Outcome. Student A was referred to an FTP panel for "[deliberately or recklessly disregarding] professional and clinical responsibilities"; "[behaving] dishonestly, fraudulently, or in a way designed to mislead or harm others"; and cheating.[1]
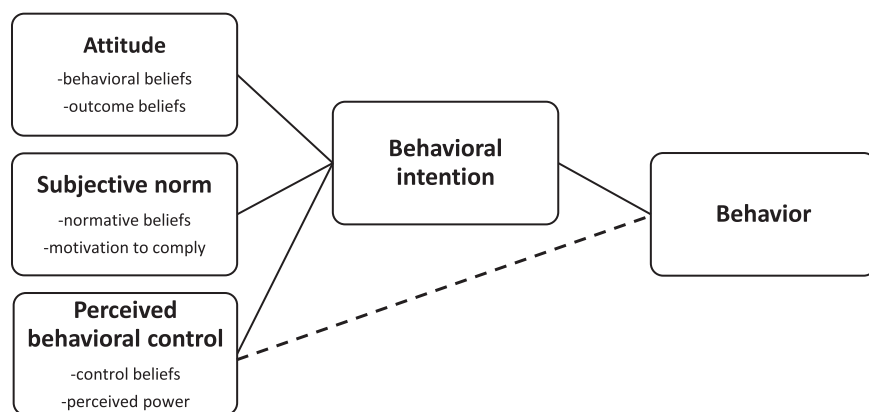

Figure 1 Graphic representing the theory of planned behavior (TPB), a deliberative processing model that explains how an individual's behavior is underpinned by his or her cognitions, with behavior being primarily dependent on the intention to perform the behavior. Intention, in turn, is determined by three variables: attitude, subjective norm, and perceived behavioral control. The solid lines indicate how the TPB variables are related to intention and thus to behavior. The dashed line indicates the direct impact that perceived behavioral control can exert on the behavioral outcome.

Her FTP was found to be breached. She was suspended from her studies for a year and asked to work with disability teams, with faculty to develop an online guide on the implications of falsifying documents in medicine, and attend GMC FTP sessions to reflect on her attitude toward professionalism. She was asked to maintain an accurate log of activities and complete a portfolio of reflective work on these activities.

The student's claim that "everyone does it" was of concern. Was there a culture within the school that promoted fraudulent behavior? A review of the school's processes to discourage such behavior showed that systems, including a quarterly review by academic advisors, were in place to identify students struggling to complete their course work. However, the review did find that the extent to which students were supported in their portfolio activities varied among advisors and that the number of activities that required sign-off was excessive. The school has subsequently introduced an e-portfolio enabling activities to be signed off and monitored remotely, allowing struggling students to be offered timely support. In addition, the number of activities requiring sign-offs has been reduced, allowing students to focus on their learning rather than paperwork.

Case 2

Student B, a first-year medical student, posts a video on his Facebook page portraying himself as a neo-Nazi with his friends as comrades, explicitly displaying racist and sexist views. The video attracts numerous comments from viewers, with student B contributing significantly with additional racist and sexist remarks.

During a meeting with the program director, student B appears embarrassed, immediately acknowledging his inappropriate behavior. He created the video for "a bit of fun" and, following its success on Facebook, carried on with the offensive discussion. He repeatedly states that the video does not reflect his beliefs and that he will accept the decision of the program director.

Student's perspective. The student confirmed his behavior and behavioral intention, admitting that he had acted without evaluating the consequences (outcome beliefs). He clearly had access to social media (control beliefs)

and thought he would not be caught (perceived power). He felt pleased by all the comments from his peers and continued to participate in the discussion (normative beliefs).

Program director's perspective. Demonstrating negative racist and sexist attitudes was unacceptable, and thinking it was funny demonstrated a failure to consider the outcomes (behavioral beliefs) or evaluate the consequences (outcome beliefs). Afterward, however, the student demonstrated insight, projecting an appropriately negative attitude toward his behavior. He acknowledged that there was no peer pressure on him to behave the way he did (normative beliefs) and recognized that his behavior deserved punishment, appreciating the outcomes of his behavior and showing evidence that he had reflected on it.

Outcome. The GMC states that "failure to keep appropriate boundaries in behaviour," including sexist and racist behavior, is unprofessional.[1] Given student B's remorse and demonstrated awareness of his projected attitude, he was allowed to continue his studies but received a formal warning from the dean that was kept in his records, and he was advised to evaluate the consequences of his behavior carefully in the future. The other students involved in the video were also issued formal warnings. Considering the role of normative beliefs in this professionalism lapse, the students involved in the video were asked to develop a teaching tool on the responsible use of social media, highlighting national guidance[44] and the university's policy on its use. To further address any underlying social norms that may still be prevalent in medical schools, student B's school has formal teachings on sexism and racism embedded within the curriculum, as well as awareness-raising workshops run by the lesbian, gay, bisexual, and transgender society.

Case 3

Student C, a fourth-year medical student, goes to Uganda for his elective. He is excited when his hospital supervisors involve him in all types of clinical work. He sees patients with conditions that he has not seen before and cannot wait to share his experiences with his friends. He takes photographs of some of the patients and posts them on Facebook, boasting

that he has performed minor procedures he would never be allowed to do back home. One of his colleagues informs the school of his posts.

At a meeting with the program director, the student expresses surprise at being summoned. When asked to reflect on his actions, he demonstrates some remorse for taking photographs of patients without their consent, but states that he was "only trying to help" the busy doctors at the hospital. He admits that he had not been trained to perform the procedures, although he had practiced them during his clinical skills sessions.

Student's perspective. The student probably felt that the school was being unfair in reprimanding him for helping busy doctors in Uganda. He expressed normative beliefs that were culturally nuanced by thinking that in Uganda, performing procedures without adequate training and breaching confidentiality might not be problematic. Moreover, the opportunity to practice skills and tell his friends was too good to forgo (control beliefs).

Program director's perspective. The student behaved unethically, performing procedures without appropriate competence, not recognizing his limitations, and posting patient photographs on social media without their consent. He demonstrated an inappropriate attitude toward confidentiality and informed consent (behavioral beliefs). His argument that he was helping out the local doctors was inappropriate because he had not adequately explored the consequences (behavioral beliefs) or the outcomes of his behavior (outcome beliefs), such as harm to the patients and disrepute to his medical school.

Outcome. The student was referred to an FTP panel for "failure to keep appropriate boundaries in behaviour," breach of confidentiality, and acting beyond his abilities.[1] At his meeting with the FTP panel, the student took full responsibility for his actions and provided a mature account of his personal reflections on his behavior, demonstrating insight into and remorse for his actions. He had already written to apologize to the doctors in Uganda and the patients whose photographs he had used. He was allowed to continue his studies but was required to write a piece on the importance of

patient confidentiality, and a written warning was placed on his record.

This case highlighted to student C's school the importance of the accountability of medical schools in sending their students to host organizations and the ethical responsibility of the visiting students.[45] At student C's medical school, clear guidance on the need to behave professionally and not practice beyond their means is now given to students before they go to host organizations. Students are also asked to consider the cultural nuances of the host country and to be sensitive to cultural differences.

Case 4

Student D, in her final year, contacts the program director to confess to a previous misrepresentation of a drug-related conviction. She had previously reported the conviction after being caught at a music festival in possession of ecstasy tablets. However, she had failed to mention that she also had some cocaine, which was part of the conviction. On finding that she had to declare this to the GMC when applying for registration, she decided to make a full confession. At an

interview with the program director, she claims she was carrying the drugs for her boyfriend and did not previously confess to the cocaine part of the conviction as she was worried about being expelled. There is no evidence of personal drug use or other drug-related convictions.

Student's perspective. The student did not confess completely when she was first convicted; having evaluated the consequences of her behavior, she worried that if she gave a full confession she would be expelled (outcome beliefs). She had acted on behalf of her boyfriend (normative beliefs) and had motivation to comply with his request. She had not considered the consequences of carrying drugs (behavioral beliefs) or the impact it would have throughout her career (outcome beliefs).

Program director's perspective. The student only admitted to possessing cocaine when she realized she had to declare convictions to the GMC. She had not weighed the consequences of a partial versus a full declaration to the school (outcome beliefs). Not only did she find it easy to carry the drugs (control beliefs), but by carrying the drugs for her boyfriend, she

demonstrated her motivation to comply with a salient other. Furthermore, all students at her university were provided with professionalism teaching, which includes the potential consequences of criminal convictions (including drug possessions) and nondisclosure of such convictions; therefore, this behavior clearly demonstrated a lack of motivation to comply with such guidance.

Outcome. The student was referred to an FTP panel for "dealing, possessing or misusing drugs" and failing to make a full declaration of a criminal conviction.[1] Her FTP was found to be breached; although the offence had occurred some years previously, the panel did not feel confident that she was currently fit to practice. She was suspended from studies for one year, during which she undertook a remedial program that involved working with patients and caregivers who had suffered harm from doctors with addiction problems. She was asked to write an essay on why honesty was central to the work of a doctor.

A worked example

Table 1 presents Case 1 as a worked example to illustrate the application

Table 1

Worked Example of How the TPB Can Be Used to Analyze Professionalism Lapses Among Medical Students

TPB variable	Decision-making process	Outcome
Behavioral intention	The behavior was not a spur-of-the-moment one. The fact that she did not attend her community placement was bad enough, but she also left the parent and patients waiting, wrote a reflective piece as though she had gone, and only expressed regret when she was caught. This justified the program director's decision to refer her to an FTP panel.	The FTP panel felt that her actions were deliberate and demonstrated a lack of sensitivity and appreciation for people with disabilities. She was suspended for a year and part of her sanctions included an extended placement in the community visiting disability teams. She was asked to maintain an accurate log of activities and reflect on lessons learned.
Attitude[a]	The student made a number of excuses for her poor behavior. She had not considered the consequences of her behavior or thought about how this may impact her studies or future career, further justifying her referral to an FTP panel.	The panel found her attitude unacceptable. She was found unsuitable to continue practicing due to her demonstrable lack of insight into her behavior. Part of her remediation plans included a formal reflective process, including attending GMC FTP sessions to appreciate the importance of professionalism and the consequences of poor behavior among doctors.
Subjective norm[b]	The student stated that "all students behaved [that] way," claiming that other students who had forged logbooks had never been caught, establishing a case that this was the norm. There was, however, no evidence that this was the case, further justifying her referral to an FTP panel.	In addition to the other actions described in this table, she was asked by the FTP panel to work with faculty to develop an online guide on the implications of falsifying documents in medicine for all students.
Perceived behavioral control[c]	According to the student, it was difficult to get activities signed off, and so it was easier to just forge the signatures. She also suspected that the logbooks were not scrutinized in detail, making the decision to forge the entries easier.	This claim by the student prompted the program director to carry out a schoolwide review into the logbook process and its monitoring. This review resulted in a shift to an e-portfolio and a reduction in the number of sign-offs required.

Abbreviations: TPB indicates theory of planned behavior; FTP, fitness to practice; GMC, General Medical Council.
[a]A function of behavioral beliefs (performing the behavior will lead to consequences) and outcome beliefs (evaluation of those consequences)
[b]A function of normative beliefs (perceptions of salient others' preferences about the behavior) and motivation to comply (the extent to which one wishes to comply with salient others' expectations).
[c]A function of control beliefs (whether one has the opportunity to perform the behavior successfully) and perceived power (the perception that certain factors have the power to facilitate or inhibit the completion of the behavior).

and utility of the TPB in the decision-making process, including sanctions and remediation, as well as how it was employed to analyze the school's culture with respect to fraudulent behavior.

Discussion

Though the challenge of defining medical professionalism has led to operational definitions focusing on behavior,[22,46,47] there is an emerging acknowledgment in the medical education community that studying attitudes is equally important.[48] The four cases we presented here contribute to the debate on decision making related to FTP in medicine through their use of the TPB to examine students' attitudes toward professionalism.

Strengths of the TPB

A strength of the TPB is that it enables behavioral determinants to be systematically examined, offering a method of standardizing FTP processes. It contextualizes behavior, accounting for factors such as cultural influences[36,37] and medical school environments (i.e., the hidden curriculum[49,50]). For example, student C behaved inappropriately in a different cultural context; although this may not mitigate his misconduct, it needs to be acknowledged as a determinant of this lapse in professionalism. As another example, student D had been informed about the consequences of drug possession but still behaved inappropriately, possibly demonstrating an acceptance of such behavior among her peers. Exploring these normative beliefs in the context of students' professionalism lapses allows them to also be tackled at an institutional level, enhancing the development of professionalism across curricula.[16]

The TPB provides a framework for the analysis of apparent remorse and can help determine whether students are faking it (i.e., aligning their behavior with normative expectations).[29,51] For example, students A, B, and C all expressed remorse; however, student A challenged her referral to an FTP panel, whereas students B and C accepted the program director's decision without dispute.

Limitations of the TPB

The application of the TPB relies on the assessment of beliefs and attitudes that are difficult to measure.[48] Identification of an attitudinal problem theoretically allows the development of a targeted remediation strategy; however, there is little evidence to support that such an intervention will lead to attitudinal change.[48] Returning to the concept of faking it,[51] the lack of such interventions provides the opportunity for a student to complete a remediation process, ostensibly having undergone an appropriate shift in attitude, without any substantive change.

Another limitation of the TPB is that it uses an individual's behavior as a proxy to analyze an organization's culture of professionalism. Given students' described respect for the medical hierarchy,[34] students may not report contextual factors that could be relevant to both the evaluation of the individual's lapse in professionalism and the school's hidden curriculum, thus limiting the generalizability of any findings.

Finally, the use of the TPB is only as good as the evidence collected. As the TPB does not inherently contain a system for collecting evidence, it relies on nonstandardized systems of evidence collection. This is not an insurmountable obstacle: The application of psychological theory to the collection of such evidence has already been proposed.[29] A combined psychological–TPB theoretical framework is certainly within the realm of possibility.

Conclusion

The interpretation of medical students' lapses in professionalism poses a challenge to medical schools' FTP panels. We propose that the TPB, with its inherent requirement for the incorporation of behavioral intention (via attitude, subjective norm, and perceived behavioral control) into FTP judgments, provides a framework to facilitate this process. The TPB is not the only theoretical framework that could be adopted, and it may not address all the subtle nuances of professionalism; however, by applying it to four complex examples of professionalism lapses among medical students, we have demonstrated how it could be used in this way.

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