Professionalism in Medical Education

Marcus A. Henning[1], Ralph Pinnock[2], Wayne Hazell[3], Susan J. Hawken[4]

[1]Senior Lecturer, Centre for Medical and Health Sciences Education, Faculty of Medical and Health Sciences, University of Auckland, New Zealand. [2]James Cook University; The Townsville Hospital; and Honorary Consultant Paediatrician, Starship Children's Hospital, Auckland, New Zealand. [3]Emergency Physician and Director of Clinical Training (Medical Education Unit) The Prince Charles Hospital; Deputy Head and Critical Care Co-ordinator, TPCH Northside Clinical School, University of Queensland; and Adjunct Professor Queensland University of Technology. [4]Senior Lecturer, Department of Psychological Medicine, Faculty of Medical and Health Sciences, University of Auckland, New Zealand.

CORRESPONDING AUTHOR: Dr Marcus A. Henning, Senior Lecturer, Faculty of Medical and Health Sciences, University of Auckland, New Zealand. Tel: +64-9-923 7392, Email: m.henning@auckland.ac.nz

As medical educators we are obliged to teach and engage students in the learning environment at many levels. First, the content of medicine requires a rigorous and comprehensive process of learning due to the innumerable facts, cognitive capacity and skills required to be a doctor. Second, is the humanistic side of medicine that's requires the development of a high sense of human sensitivity so that rapport with colleagues, patients and other staff is maximized. Third, relates to the organizational aspect of being a clinician and this requires a refined sense of time management and planning so that tasks are executed with precision and elegance.

Although, the notion of professionalism is embedded within all these levels there is an inherent difficulty in gaining a clear picture of what it is (1, 2). In their article, Hilton and Southgate[2] clearly introduced the historical and societal determinants behind the notion of professionalism with a focus on the medical context. They state in their article that professions have a number of attributes related to "a body of specialist knowledge and skills; a commitment to high standards of service; varying degrees of self-regulation and autonomy; and moral and ethical standards (p. 267)." They propose that professionalism in doctors has

diverse meanings depending on context and individual interpretation.

We think that is it relatively clear-cut to suggest that clinicians need to be abreast of the latest development in medicine and this is especially important in their field of expertise. Second, we feel that clinicians need to have rapport skills to deal with faculty, students, patients and administrative staff. In addition, clinicians also need to cope with the day-to-day tasks of operation as clinician, teacher, and social and personal being. At the fourth level, clinicians also need to have a clear sense of ethical conduct, which needs to be maintained throughout their professional lives.

The subsequent discussion aims to address four questions. First, what does it mean to be a professional clinician and teacher? Second, how can clinician teachers and medical educators teach professionalism? Thirdly, how can clinician teachers and medical educators assess its presence or absence in their students and colleagues? And lastly, how can clinician teachers and medical educators interpret assessments and remediate unprofessional conduct?

What does it mean to be a professional clinician and teacher?

The Royal College of Physicians and Surgeons of Canada (3) have developed a comprehensive set of criteria around the idea of 'the medical expert'. One of the interconnecting roles is defined as professional (4) which defines professionalism in terms of a commitment "to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behavior". This college also emphasizes the need to demonstrate competencies in areas of ethical practice, profession-led regulation, physician health, and sustainable practice.

The Royal Australasian College of Physicians (5) have also detailed the complex nature of the term professionalism and its relation to performance. According to this College,

physicians need to evidence 'demonstrable professionalism' by embracing a transparent process whereby key stakeholders are made aware of "doctors' competence (what they are able to do)" in line with their "performance (what they actually do)". To demonstrate professionalism requires a strict definition so that standards can be developed. In their guidelines, The Royal Australasian College of Physicians[5] have created a framework in line with ten criteria: (1) quality and safety, (2) cultural competency, (3) communication, (4) collaboration and teamwork, (5) leadership and management, (6) decision making, (7) health advocacy, (8) the broader context of health, (9) teaching, learning and research, and (1) ethics. Within each of these criteria are explanations, e.g., quality and safety refers to 'maintaining medical expertise', 'monitoring and evaluating care', and 'defining and working within scope of practice'.

The documents developed by the Royal Australasian College of Physicians and the Royal College of Physicians and Surgeons of Canada create a gold standard in reference to clinician professionalism and many of these attributes, if not all, can be applied to the role of the clinician teacher. In their systematic review of what constitutes a good clinical teacher in medicine, Sutkin and colleagues (6) deconstructed the role of the clinician teacher in terms of physician, teacher, and human characteristics. The notion of professionalism is embedded in the physician's characteristics and is defined under the category 'exhibits professionalism' which contains attributes such as lifelong learner, self-directed learner and developer, self-reviewer, collaborator, reflexive, and insightful.

As clinician teacher the emphasis is on the transference of professional behaviors and skills, clinical knowledge and attitudes with respect to colleagues, students, and patients (1). The notion of lifelong learner is very important and the clinician teacher needs to be responsible to self-assessment and to seek out assessment of competencies so that teaching praxis is constantly improved (7). There is also the sense that clinician teachers need to balance both their

professional and personal lives. There are several conundrums here related to the notion of priorities, in that clinicians need to consider the different situations and stakeholders when operating as clinician teacher. For example, when in the practice of medicine the first priority is towards patients care, but there is also consideration of colleagues, the caring institution and profession, codes of conduct, and regulatory mechanisms. Conflict may occur between these entities especially if different stakeholders have different concepts or interpretations of the notion of professionalism. We feel that the underlying assumption throughout the literature is that a good clinician teacher embraces aspects of professionalism and this professionalism is intertwined within both their clinical and teaching roles, but there are grey areas that can create ambiguity, conflict, and confusion.

How can clinician teachers and medical educators teach professionalism?

Earlier work in the 1990s suggested the need for more transparent and formalized methods of teaching professionalism at the undergraduate level (8). The above section affirms that clinicians and regulatory bodies have developed comprehensive criteria defining professionalism and that the notion of professional '*clinician teacher*' is likely an extension of their notion of '*professional clinician*'.

Much of the literature, espousing medical education, refers to the teaching of professionalism. Riley and Kumar suggest that the teaching of professionalism originates from three sources: medical school or university, role models, and learning through experience. Harden and Crosby (7) have described the twelve roles of the clinical teacher. One of the roles described by Harden and Crosby centers around the idea of role model and it is within this role that students learn the attitudes, skills and behaviors associated with being a professional clinician. According to Harden and Crosby, the teacher as a clinician should model or exemplify what should be learned. Students learn by observation and imitation of the clinical teachers they respect. Students learn not just from what their

teachers say but from what they do in their clinical practice and the knowledge, skills and attitudes they exhibit (p. 338).

This aspect of teaching and learning encompasses not only the taught and declared curriculum, but also the hidden curriculum. The hidden curriculum is a powerful force that engenders change outside the formalized aspects of teaching and can manifest itself in the forms of actual teaching practice creating a disconnection between formal learning and actual praxis (9, 10). O'Callaghan (10) in her paper refers to the powerful emotive forces that exist within teacher and caring encounters. Within medical schools students are often taught about models of communication and engagement that are not mirrored in the hospital environment thus engendering a change in learning strategies. As one clinician once said to me, she was amazed at how gentle and professional a consultant was to their patient and then outside the patient's room turned on their students in a most hostile manner using a strategy often referred to as 'teaching by humiliation'. It is also important to recognize that professional conduct as students appears to have some bearing on professional conduct as clinicians, for example disciplinary action as a clinician has been found to be strongly associated with unprofessional conduct as a medical student (11,12).

It is, therefore, the inconsistencies between learned modes of professionalism (within Universities and clinical skills centers) and the actual clinical learning experiences (in the hospitals) that are likely to be the most difficult challenges for teachers and learners in terms of imparting the characteristics of professional practice. This line of logic suggests that Universities need to prepare students for the clinical environment and to teach strategies that students can use when facing ethical dilemmas, the proximity between clinical environment and University training needs to be constantly reviewed so that clinicians have a voice in the way students are taught. However, gaining a consensus amongst clinical teachers is likely to be difficult with respect to the best approaches to teach and assess this aspect of the curriculum.

How can clinician teachers and medical educators assess its presence or absence in their students and colleagues?

There is a growing interest in the assessment of professionalism. In their review of the literature, Lynch and colleagues (13) found that assessment of professionalism was aligned to certain themes. The first theme centers around ethics and this was linked to certain sub-themes, namely "morality, ethical principles, honor codes, social norms, deception, abuse or mistreatment, cheating, disclosure, and sexual misconduct (p. 368)". The second theme relates to the notion of personal characteristics which assess areas of emotional or social intelligence, personal values, empathy, trustworthiness, negative mind states and inflexibility. A further theme that appears to be important revolves around the idea of diversity which encompasses areas of cultural competence, cultural responsiveness, social status, economic well-being, gender, age and/or disability. Lynch and colleagues also mention certain inventories that are in use that aim to measure behavioral aspects of professionalism and these include: the Nurse Evaluation of Medical Housestaff Form (14), the Amsterdam Attitudes and Communication Scale (15), Barry's Challenges to Professionalism Questionnaire (16), and the Humanism Scale (17); each with its own strengths as a measurement tool.

In a more formal review of the literature with the view to developing an assessment protocol, Wilkinson and colleagues (18) delineated five clusters of professionalism: ethical practice, effective interactions with patients as significant others, effective interactions with colleagues within the health system, reliability, and commitment to developing competence. As with other authors in this area, the defining of professionalism becomes critical to the assessment of it (19). With these clusters in mind Wilkinson and colleagues developed a blueprint for assessment that included an assessment of an observed clinical encounter, collated views of coworkers, records of incidents of unprofessionalism, simulation, paper-based tests, patient opinions and self-administered rating scales. In an earlier paper, Fontaine and Wilkinson (20) appraised the Professional Attitudes and Skills Assessment Form (PASAF) which comprises four dimensions related to clinical skills, tutorial performance, communication, and teamwork skills. The aim of the PASAF was to detect a concern in any of the four dimensions which could then be acted upon. The PASAF was seen as a useful process as it provides useful behavioral definitions and can be longitudinally employed to detect changes over time.

The challenge in developing an assessment process that covers the components of professionalism is to ensure the different elements combine to form a meaningful whole (21, 22). In their paper, Van Der Vleuten and colleagues (23) indicated that a good assessment process that covers various entities inevitably requires several competency mechanisms and multiple sources of data with reference to several credible standards. Not an easy task to do. The key is to ensure that all components and multiple sources point in a desired direction. Van Der Vleuten and colleagues (23) also reiterated the need for assessment to be a feedback loop which would have benefits for the ongoing development of the student. This thinking is in line with Lynch and colleagues (13), who suggested that professionalism should be assessed in a variety of ways incorporating formative methods. More specifically, they emphasized that it is important to note that feedback derived from assessment and constructive feedback mechanisms will likely engender professional behaviors and this process needs to be done early in the training process, conducted frequently, and provide opportunities for discussion. Goldie (21), in his recent article, recognized the complex nature of assessing professionalism and in addition to the above discussion suggests the need for cultural relevance and contextual recognition.

How can clinician teachers and medical educators interpret assessments and remediate unprofessional conduct?

In a recent article, Buchanan and colleagues (24) present clear guidelines around assessment and remediation of unprofessional conduct. They see lapses in professional conduct as being behaviorally defined according to: lack of respect for patients; performance (inability to concentrate on the tasks); attitude (lack of humility or being over confident); or lack of accountability (tardiness). They also suggest that clinical teachers can address concerns related to dress code, punctuality communication and study application. In a broad sense, this all seems perfectly reasonable. However there are certain issues here around levels of subjective acceptability. For instance, in a recent article a student was berated for falling asleep in a lecture (25), which was considered unprofessional by the clinical teacher but not the student. This is certainly one of those grey areas whereas in contrast most (it not all) would agree that following asleep whilst consulting a patient is clearly not acceptable.

Interpretation and remediating 'unprofessional conduct' is certainly the more complicated end of the formula. Given that professionalism is a multi-layered concept that is difficult to teach and assess. As a corollary it becomes reasonable to suggest that the interpretation will likely be even more difficult to discern in absolute terms given that professionalism has aspects that can be measured, but aspects that are defined by ideology, culture and context. In their article, Hodges and colleagues (22) quite rightly emphasize that professionalism is likely a sociological construct that defines the working role of the professional. As such, "professionalism is something that serves a social role of some higher order (p. 360)". Professionalism is, thus, both conceptual and functional. A meaningful way ahead is through continual dialogue between professionals from different disciplines, such as law, ethics, health sciences, education, business, sociology, anthropology, and psychology. Clearly in medicine the criteria for professional action have been delineated in college guidelines and, therefore, the problem is usually one of interpretation.

In ethics, Hauser and his colleagues (26) created moral dilemmas that could elucidate thinking around perceptions regarding situations that are not easily solved. In the normal state of practice in non-stressful environments it is likely that most medical practitioners will operate within, and adhere to, a professional code. It is problematic when situations arise that are not so easily solved, thus creating moral or ethical confusion which creates the risk for engagement in unprofessional behavior. Hauser and his colleagues (26) have created some interesting ideas around the use of scenarios that are intentionally ambiguous in terms of drawing out discussion around professional conduct; eliciting responses in an intuitive and/or logical manner. Such scenarios can address issues related to the hidden curriculum which can exacerbate ambiguous contexts, such as when students are taught professional attitudes at medical school but experience and learn different codes of conduct in the clinical environment (10) For example, in their study, Ho et al (27) asked medical students to respond to videos showing professionally challenging situations and these videos allowed students to express ideas related to issues such as patient care, honest behavior, accountability, ethics and so forth. An area of common conflict with regard to patient care and collegial co-operation could also be considered. For example, 'Do you put patients or collegial relations first - or can you do both?'

One area of debate that is ongoing relates to the issues of cultural difference or similarity (27-31). Franz van der Horst and Paul Lemmens (30) suggested that the importance of "culture as a contextual factor" is that it underlies the meaning of professionalism. They further emphasize the need to reconsider the frames of reference for research in this area and to establish formalized teaching from that learnt via the hidden curriculum. This article by van der Horst and Lemmens raises the complexity of comparison studies in this area and highlights the need to consider the various cultural and regional

differences and the factors within cultures. Culture has many fundamental elements such as values, language, belief systems, behaviors, diets, dress sense and so on that define a specific group entity. And within each group those values and norms that define the understanding of the members define the ways they interpret the meaning of professionalism.

Reflecting on the substance of this editorial and its review of the main issues surrounding professionalism, several comments can be made. First, it is clear that many academics, professionals, clinicians and their respective organizations have developed considerable resource in producing definitions, guidelines and ideas surrounding the notion of professionalism. Second, there are numerous ways in which professionalism can be taught in both the formal and informal curricula. Third, assessment and evaluation of professionalism is varied amongst practitioners and educators, although organizations have developed some innovative ways of assessing this construct, such as blue-printing the various combinations related to the teaching and learning of professionalism. Lastly, there is a growing literature that is evolving that consider the underlying factors influencing the teaching and learning of professionalism such as cultural and ideological differences. It is also clear that professionalism is not a fixed entity and over time will develop. Professionalism will likely change in line with changes in our understanding of ethics and morality and legislative changes both in government and within organizations.

Reference

1. Riley S, Kumar N. Teaching medical professionalism. *Clinical Medicine, Journal of the Royal College of Physicians.* 2012;12(1):9-11.
2. Hilton S, Southgate L. Professionalism in medical education. *Teaching and Teacher Education.* 2007;23(3):265-279.
3. Royal College of Physicians and Surgeons of Canada. CanMEDS: better standards, better physicians, better care. 2013; http://www.royalcollege.ca/portal/page/portal/rc/canmeds. Accessed February 14, 2013.
4. Royal College of Physicians and Surgeons of Canada. Professional. 2013; http://www.royalcollege.ca/portal/page/portal/rc/canmeds/framework#professional. Accessed February 14, 2013.
5. The Royal Australasian College of Physicians. *Supporting Physicians' Professionalism and Performance: A Guide for Physicians in Australia & New Zealand.* Wellington: The Royal Australasian College of Physicians and the Medical Indemnity Industry Association of Australia; 2012.
6. Sutkin G, Wagner E, Harris I, Schiffer R. What makes a good clinical teacher in medicine? A review of the literature. *Academic Medicine.* 2008;83(5):452.
7. Harden R, Crosby J. AMEE Guide No 20: The good teacher is more than a lecturer-the twelve roles of the teacher. *Medical Teacher.* 2000;22(4):334-347.
8. Swick HM, Szenas P, Danoff D, Whitcomb ME. Teaching professionalism in undergraduate medical education. *JAMA: the journal of the American Medical Association.* 1999;282(9):830-832.
9. Marinker M. Myth, paradox and the hidden curriculum. *Medical Education.* 2009;31(4):293-298.
10. O'Callaghan A. Emotional congruence in learning and health encounters in medicine: addressing an aspect of the hidden curriculum. *Advances in Health Sciences Education.* 2012:1-13.
11. Papadakis MA, Hodgson CS, Teherani A, Kohatsu ND. Unprofessional behavior in medical school is associated with subsequent disciplinary action by a state medical board. *Academic Medicine.* 2004;79(3):244-249.
12. Papadakis MA, Teherani A, Banach MA, et al. Disciplinary action by medical boards and prior behavior in medical school. *New England Journal of Medicine.* 2005;353(25):2673-2682.
13. Lynch DC, Surdyk PM, Eiser AR. Assessing professionalism: a review of the literature. *Medical Teacher.* 2004;26(4):366-373.
14. Butterfield PS, Mazzaferri EL. A new rating form for use by nurses in assessing residents' humanistic behavior. *Journal of general internal medicine.* 1991;6(2):155-161.
15. De Haes J, Oort F, Oosterveld P, Cate Ot. Assessment of medical students' communicative behaviour and attitudes: estimating the reliability of the use of the Amsterdam attitudes and communication scale through generalisability coefficients.

Patient Education and Counseling. 2001;45(1):35-42.

16. Barry D, Cyran E, Anderson RJ. Common issues in medical professionalism: room to grow. *The American journal of medicine.* 2000;108(2):136-142.

17. Hauck FR, Zyzanski SJ, Alemagno SA, Medalie JH. Patient perceptions of humanism in physicians: effects on positive health behaviors. *Family medicine.* 1990;22(6):447.

18. Wilkinson TJ, Wade WB, Knock LD. A blueprint to assess professionalism: results of a systematic review. *Academic Medicine.* 2009;84(5):551-558.

19. Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA: the journal of the American Medical Association.* 2002;287(2):226-235.

20. Fontaine S, Wilkinson TJ. Monitoring medical students' professional attributes: Development of an instrument and process. *Advances in Health Sciences Education.* 2003;8(2):127-137.

21. Goldie J. Assessment of professionalism: A consolidation of current thinking. *Medical Teacher.* 2013;35:e952-e656.

22. Hodges BD, Ginsburg S, Cruess R, et al. Assessment of professionalism: Recommendations from the Ottawa 2010 Conference. *Medical Teacher.* 2011;33(5):354-363.

23. Van Der Vleuten CP, Schuwirth LW. Assessing professional competence: from methods to programmes. *Medical Education.* 2005;39(3):309-317.

24. Buchanan AO, Stallworth J, Christy C, Garfunkel LC, Hanson JL. Professionalism in Practice: Strategies for Assessment, Remediation, and Promotion. *Pediatrics.* 2012;129(3):407-409.

25. Carr N. Is sleeping in lectures a professionalism issue? *The Clinical Teacher.* 2012;9(3):198-198.

26. Hauser M, Cushman F, Young L, Jin RK-X, Mikhail J. A dissociation between moral judgments and justifications. *Mind and Language.* 2007;22(1):1-21.

27. Ho MJ, Lin CW, Chiu YT, Lingard L, Ginsburg S. A cross- cultural study of students' approaches to professional dilemmas: sticks or ripples. *Medical Education.* 2012;46(3):245-256.

28. Chandratilake M, McAleer S, Gibson J. Cultural similarities and differences in medical professionalism: a multi- region study. *Medical Education.* 2012;46(3):257-266.

29. Tsai S-L, Ho M-J, Hirsh D, Kern DE. Defiance, compliance, or alliance? How we developed a medical professionalism curriculum that deliberately connects to cultural context. *Medical Teacher.* 2012;34(8):614-617.

30. van der Horst F, Lemmens P. Medical education and professionalism across different cultures. *Medical Education.* 2012;46(3):238-239.

31. Windsor JA, Rossaak JI, Chaung D, Ng A, Bissett IP, Johnson MH. Telling the truth to Asian patients in the hospital setting. *The New Zealand Medical Journal.* 2008;121(1286):92-99.