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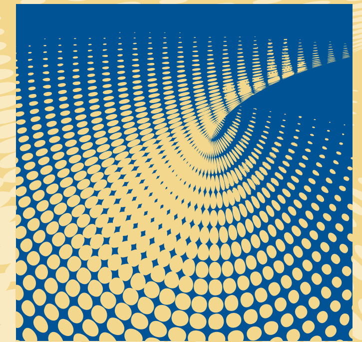
A PRACTICAL GUIDE TO

Teaching and Assessing the ACGME Core Competencies



SECOND EDITION

ELIZABETH A. RIDER, MSW, MD, FAAP • RUTH H. NAWOTNIAK, MS, C-TAGME

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HCPro

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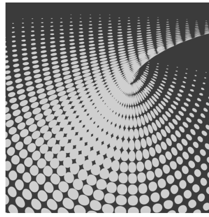

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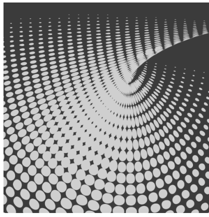

About the Authors

Elizabeth A. Rider, MSW, MD, FAAP

Elizabeth A. Rider, MSW, MD, FAAP, is director of academic programs at the Institute for Professionalism and Ethical Practice, Children's Hospital Boston, where she creates and implements local and national courses to enhance relational learning and communication skills for medical education leaders, faculty, residents, and practicing clinicians. She is also director of programs for communication skills at the John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital, a center dedicated to revitalizing and redesigning primary care and to enhancing patients' and families' experience of care. She is an assistant professor of pediatrics at Harvard Medical School (HMS).

A graduate of HMS, she completed her pediatric residency at Children's Hospital Boston and fellowship in general academic pediatrics at Massachusetts General Hospital. She also holds a master's degree in clinical social work from Smith College. A former child and family therapist, she is board certified in both pediatrics and clinical social work (LICSW, BCD), and is a Fellow of the American Academy of Pediatrics, the American Academy on Communication in Healthcare, and the National Academies of Practice.

She directs the international Harvard faculty development course "Difficult Conversations in Healthcare: Pedagogy and Practice" and the Difficult Conversations Program for Residents at Children's Hospital Boston. She also codirects the year-long psychosocial pediatrics course "Emotional and Psychosocial Issues in Children and Families: Pediatrics for the New Millennium."

She designs and leads educational programs at three Harvard-affiliated hospitals and did similar work at HMS. She was a member of the Kalamazoo Consensus Statement Group on Physician–Patient Communication in Medical Education, and brought the Kalamazoo framework to HMS, where she and colleagues implemented assessment in communication competencies across all four years and a communication skills curricular model in the core medicine clerkships. At HMS, Rider was also coordinator of faculty development for the resident as teacher programs, and taught for a number of years in the Patient-Doctor III course. She currently serves as faculty for the Harvard Macy Institute Program for Educators in Health Professions.

A winner of various teaching awards, Dr. Rider teaches and consults nationally and internationally on communication skills, relationship-centered care, reflective practice, and medical education program development. In 2007, she was invited by the Education Ministry of Taiwan to teach 125 medical education leaders from Taiwan's 11 medical schools about teaching, assessing, and integrating communication skills into medical education curricula.

She was elected to the Medicine Academy of the National Academies of Practice as a Distinguished Scholar and Practitioner, and was appointed co-chair of the Medicine Academy in 2006. The National Academies of Practice, comprised of Academies of 10 healthcare professions, serves as a distinguished policy forum to advise U.S. governmental bodies on interprofessional approaches to healthcare.

She serves on the National Board of Medical Examiners' Communication Skills Task Force. She is section editor (Reflective Practice) for the international journal *Patient Education and Counseling* and an associate editor for *Medical Encounter*. She practices pediatrics part-time at Roslindale Pediatric Associates in Boston, and was selected by her peers for inclusion in *Best Doctors*.

Ruth H. Nawotniak, MS, C-TAGME

Ruth H. Nawotniak, MS, C-TAGME, is a co-founder of the National Board for Certification of Training Administrators of Graduate Medical Education Programs (TAGME) and its first president. She spearheaded the creation of TAGME to establish standards for the profession, to acknowledge the expertise needed to successfully manage graduate medical education programs, and to recognize those training program administrators who have achieved competence in all fields related to their profession. She worked on certification development for several years before becoming chair of the communications committee. Nawotniak also serves as the training program administrator for the general surgery residency program at the University at Buffalo-SUNY and is the training program administrator liaison to the Graduate Medical Education Committee.

In addition, she has presented at teaching hospitals and academic centers across the country. Her topics include the professional coordinator, coordinator certification, new program coordinators, developing goals and objectives, and various activities and tasks of a program administrator.

She has authored and/or co-authored many publications on various facets of graduate medical education, with particular emphasis on aspects of managing residency training programs. She also holds a master's degree in English education.

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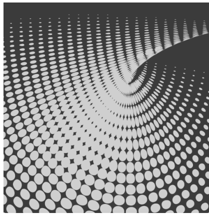

About the Contributors

Judith L. Bowen, MD, FACP

Judith L. Bowen, MD, FACP, is adjunct professor of medicine at the Oregon Health and Science University (OHSU) School of Medicine in Portland, Oregon. A graduate of Williams College and Dartmouth Medical School, she completed categorical internal medicine residency training at Virginia Mason Hospital in Seattle, where she later served as residency director. She has advanced training in healthcare ethics (1991) and medical education (2006), both from the University of Washington.

She has received numerous teaching awards including the regional Society of General Internal Medicine (SGIM) Clinician-Teacher Award of Excellence (2002) and the national SGIM award, *Scholarship in Educational Methods and Teaching* (2003). In 2009, Dr. Bowen received the distinguished Dema C. Daley Founder's Award from the Association of Program Directors in Internal Medicine.

From 1998 to 2009, Bowen served as chief of the Division of General Internal Medicine & Geriatrics in the Department of Medicine at OHSU. She also served as the associate residency program director for primary care internal medicine. In that role, she developed and implemented several innovative curricula, including a nationally recognized program in chronic care and quality improvement.

Currently, she serves as the co-chair of the SGIM's Task Force on the Patient-centered Medical Home (PCMH) and the director of the PCMH Education Summit. In 2001, Dr. Bowen was elected to serve on the Research in Medical Education (RIME) conference committee for the Association of American Medical Colleges (AAMC) and subsequently selected to serve as Conference Chair in 2005.

William T. Branch, Jr., MD

William T. Branch, Jr., MD, is Carter Smith, Sr., professor of medicine and director of the Division of General Internal Medicine at Emory University School of Medicine. He founded the primary care residency at the Brigham and Women's Hospital in 1974, among the first primary care residency programs. He was a key leader of the New

Pathway project at Harvard Medical School, serving as coordinator of the required first-year Patient Doctor Course in 1988 and director of the required third-year Patient Doctor Course from 1989 to 1995.

He attended the formative meeting of the SGIM thirty-two years ago. Dr. Branch served as a member of the SGIM Council and later as secretary. He was the first leader of the Clinician-Educator Initiative and co-edited the JGIM Supplement on the Clinician-Educator. He was the second recipient of SGIM's National Award for Career Achievements in Medical Education. He is a facilitator in the American Academy on Communication on Healthcare (AACH) and currently is immediate past President of the AACH.

At Emory University, he served as director of the Division of Internal General Medicine. He more than tripled the size of the division, and founded a primary care residency program and a faculty development program for young faculty members. He planned and implemented a required end-of-life course for Emory medical students, and is one of three co-directors of Emory's four-year "Being a Doctor" course.

Eugene C. Corbett, Jr., MD, FACP

Eugene C. Corbett, Jr., MD, FACP, is a general internist with a clinical education background in surgery, internal medicine, and public health. Following 11 years of rural general practice experience, he serves full time in an academic career at the University of Virginia School of Medicine as a clinician, teacher, and educator since 1985. His medical education interests include clinical skills education, physical examination, and curriculum and faculty development in both undergraduate and graduate education.

He has also been involved with the AAMC as chair of its Clinical Skills Task Force. This national consensus effort is focused upon advancing clinical performance education in the undergraduate medical curriculum. The Task Force published a number of monographs containing recommendations regarding the design and content of clinical skills education curricula. These include a model that specifies the generic set of patient care competencies required of all physicians.

He has received many recognitions and awards for his work in medical education. Most recently, he received the Robert J. Glaser Distinguished Teacher Award, co-sponsored by the national honorary society, Alpha Omega Alpha, and the AAMC.

Richard L. Cruess, MD

Richard L. Cruess, MD, graduated with a Bachelor of Arts from Princeton in 1951 and a medical degree from Columbia University in 1955. He is professor of orthopedic surgery and a member of the Centre for Medical Education at McGill University. An orthopedic surgeon, he served as chair of orthopedics (1976–1981), directing a basic science laboratory and publishing extensively in the field. He was dean of the faculty of medicine at McGill University from 1981 to 1995. He was president of the Canadian Orthopedic Association (1977–1978), the American Orthopedic Research Society (1975–1976), and the Association of Canadian Medical Colleges (1992–1994). He is an officer of The Order of Canada and of *L'Ordre National du Québec*. Since 1995, with his wife Sylvia Cruess, MD, he has taught and carried out independent research on professionalism in medicine. They have published widely on the subject and been invited speakers at universities, hospitals, and professional organizations throughout the world.

Sylvia R. Cruess, MD

Sylvia R. Cruess, MD, graduated from Vassar College with a Bachelor of Arts in 1951 and a medical degree from Columbia University in 1955. She is an endocrinologist, professor of medicine, and a member of the Centre for Medical Education at McGill University. She previously served as director of the metabolic Day Centre (1968–1978) and as medical director of the Royal Victoria Hospital (1978–1995) in Montreal. She was a member of the Deschamps Commission on Conduct of Research on Humans in Establishments. Since 1995, with her husband Richard Cruess, MD, she has taught and carried out research on professionalism in medicine. They have published extensively on the subject and been invited speakers at universities, hospitals, and professional organizations throughout the world.

F. Daniel Duffy, MD, MACP, FAACH

F. Daniel Duffy, MD, MACP, FAACH, is dean of the University of Oklahoma School of Community Medicine in Tulsa. He and colleagues are leading development of a four-year medical school program that integrates clinical medicine with the principles and practices of trans-disciplinary health and care for whole communities.

Previously, he was executive vice president for the American Board of Internal Medicine (ABIM) where he introduced the practice of quality improvement into the maintenance of certification programs for practicing physicians in the ABIM Practice Improvement Modules. While at the ABIM, he also held an adjunct professorship at the University of Pennsylvania in internal medicine where he taught principles of medical education. Prior to his

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service to the certification movement, he was chair of the Department of Medicine at the University of Oklahoma in Tulsa, where he was honored with the Stanton L. Young Master Teacher Award in 1989.

He served as a director of the American Board of Medical Specialties, regent for the American College of Physicians, and Oklahoma governor for the College. He is a founding member of the American Academy on Communications in Healthcare where he served as chair of the Board of Directors. He also served on and chaired the ACGME's Residency Review Committee for Internal Medicine.

He received a bachelor's degree from the University of Pittsburgh and medical degree from Temple University Medical School. He completed residency training in internal medicine and fellowship training in pulmonary disease at the University of Oklahoma Health Sciences Center. Though his board certification in internal medicine is time-unlimited, Dr. Duffy voluntarily renewed his certificate in 2006.

Frederic W. Hafferty, PhD

Frederic W. Hafferty, PhD, is professor of behavioral sciences at the University of Minnesota School of Medicine-Duluth. He received his undergraduate degree in social relations from Harvard University in 1969 and his PhD in medical sociology from Yale in 1976. He is the author of *Into the Valley: Death and the Socialization of Medical Students* (Yale University Press); *The Changing Medical Profession: An International Perspective* (Oxford University Press), with John McKinlay; and the recently published *The Sociology of Complexity: A New Field of Study* with Brian Castellani (Springer).

He is currently working on a volume tracing the hidden curriculum in medical education. He is past chair of the Medical Sociology Section of the American Sociological Association and associate editor of the *Journal of Health and Social Behavior*, and currently sits on the AAMC's Council of Academic Societies. Research focuses on the evolution of medicine's professionalism movement, mapping social networks within medical education, the application of complexity theory to medical training, issues of medical socialization, and disability studies.

Stacy M. Higgins, MD, FACP

Stacy M. Higgins, MD, FACP, is the associate program director for ambulatory education and the director of the primary care track internal medicine residency program at Emory University School of Medicine in Atlanta.

After graduating from Dartmouth College in 1989, she received her medical degree from Cornell University Medical College in New York in 1995. She completed residency training in internal medicine at Columbia University's Presbyterian Hospital, followed by a year as chief medical resident. She joined the faculty of Emory

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University's School of Medicine in 1999, and is clinically based at Grady Hospital. She also works in immigrant health at the International Medical Clinic, as well as women's health in the Women's Clinic.

David C. Leach, MD

David C. Leach, MD, is the retired CEO of the ACGME. He was born in Elmira, New York, received a Bachelor of Arts from St. Michael's College of the University of Toronto in 1965, and a medical degree from the University of Rochester School of Medicine and Dentistry in 1969. He completed residency training in internal medicine and endocrinology at the Henry Ford Health System (HFHS) in Detroit, and he is certified in those disciplines. He also had additional training in pediatric endocrinology. He was awarded the A Good Samaritan Award by Governor John Engler for his work of over 25 years at a free clinic in Detroit.

He was assistant dean at the University of Michigan for several years, primarily directing the HFHS experiences for students. He was a residency program director and designated institutional official at HFHS. He is interested in how physicians acquire competence and are enabled to be authentic practitioners of the art, science, and craft of medicine. He received grant support for innovative curricula for both medical students and residents from the Robert Wood Johnson Foundation and the Pew Charitable Trust. He is interested in Achaordic organizations, the teaching of improvement skills, aligning accreditation with emerging healthcare practices, and the use of educational outcome measures as an accreditation tool. He has received honorary degrees from five medical schools.

He is interested in honoring program directors through the Parker J. Palmer Courage to Teach award. He is a member of the Gold Humanism Honorary Society and is deeply interested in the use of values as well as rules in guiding the behavior of physicians and teachers. He believes that we teach who we are as well as what we are. He is the 2007 recipient of the Abraham Flexner Award for Distinguished Service to Medical Education.

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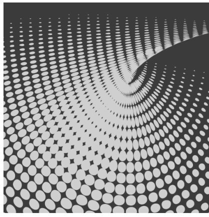

Foreword

David C. Leach, MD

It is a privilege to be asked to write this foreword to *A Practical Guide to Teaching and Assessing the ACGME Core Competencies*, Second Edition. As the competency movement developed and the accompanying ACGME requirements were deployed, many program directors, faculty, and educational coordinators said, "Look, we are busy people; just tell us what to do." This book fulfills that need, but it also does much more.

Career pathways began to open up for those who took education seriously; grants became available, and publications resulted. The importance of resident physician training became evident. This book also serves the needs of those who want to dive deeper into the phenomenon of physician competence. In this foreword, I have decided to share my observations on the competency movement and my journey toward understanding the movement.

I am an endocrinologist who was primarily interested in medical student education until 1983 when I was asked to become a program director for a transitional-year residency at my institution. Thinking about how my 20 residents were learning and moving toward competence changed my life. I then became a designated institutional official and had stewardship over about 50 residency programs that housed 800 residents. In 1997, after 14 years of experience with residents, I was asked to serve as the executive director of the ACGME and did so for 10 years. I retired in 2008 and am now free to speak my mind (the little that's left of it), and would like to encourage those who take education seriously—it is a terrific vocation.

In September 1997, the ACGME committed to the use of educational outcomes as an accreditation tool. We began a process designed to help us understand what that meant. Research identified key publications on physician competence, and we settled on about 84 frequently mentioned aspects of competence thought to be important. Susan Swing, PhD, ACGME's director of research, surveyed several different constituents including deans, hospital CEOs, patients, program directors, faculty, residents, public health officials, and policy leaders who helped us rank the various competencies by their importance and the feasibility of measuring competence in them. Paul Batalden, MD, a program director from Dartmouth Medical School, whose importance in the

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competency movement cannot be overstated, chaired an advisory committee of experts in education and assessment. Over the course of a year and a half, the advisory committee created a recommendation to the ACGME board which in turn adopted the six competencies.

We settled on six for two main reasons. First, we knew that most people could remember six or seven things but not more, and we wanted to avoid the necessity of going to a manual whenever discussions about competency arose. We also wanted the competencies to foster conversations across the various specialties and to be general enough to include all physicians, not just particular specialties.

We decided to create a timeline gentle enough to give the field time to get the movement right. Phase One, a one-year phase, was an invitational phase. In essence, we said to the GME community, "We invite you to respond to the challenge of teaching and assessing these competencies." We wanted the experience of early adopters to inform our next steps. Phase Two was titled "Clarifying the meaning and sharpening the focus of the competencies." This four-year phase was designed to get real about the meaning and assessment of each competency and to be clear about how they would be used in the accreditation of programs. Phase Three, another four-year phase, was designed to link measured improvement in competency teaching and assessment with improvements in patient care and the accreditation system. Phase Four consisted of ongoing improvement in the teaching and assessment of resident physician competence.

Several lessons were learned over the following few years. I would like to highlight these few:

1. Once the basic vocabulary, knowledge, and rules of a discipline are mastered, competence can be thought of as the demonstrated habit of reflective practice. It seems to me that this definition contains all the crucial elements: To become competent you have to have experience; to reflect on the experience you must have a system in place that can document those facts. Stages before competence (novice and advanced beginner, per the Dreyfus brothers1) involve learning the vocabulary and rules, and stages after (proficient, expert, and master) involve an ever-deepening practical wisdom. Competence is at the nexus of these two worlds: that is, between passing a multiple-choice exam and actually being useful to patients. Context assumes a more important role and the rules. Although still fundamental, rules become interpreted in the light of context. Medicine is both a science (generalizable science-based knowledge) and an art (particular patients and the contexts of their reality). Competence is generated where rules meet contexts and accountability for decisions is made. Once the rules of a given skill are mastered, the emergence of competence depends on practice and reflection on the experiences of practice. Reflection, in turn, requires solitude and community: solitude to organize and clarify one's own thinking about experience, and community to see if one's observations and conclusions hold up under scrutiny.

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Competence and community are interdependent. The six competencies identified by the ACGME and widely adopted by other organizations are designed to, in the words of the late Marvin Dunn, "enable conversations about the work of medicine." They help organize reflections on experience and conversations in community on reflected experiences. This second edition of *A Practical Guide to Teaching and Assessing the ACGME Core Competencies* continues the conversation and offers additional clarity about just how one might teach and assess these competencies.

2. If you are interested in teaching and assessing competence, you'd better get comfortable with paradox. Paradoxes are encountered whenever competency is taken seriously; and it is necessary to honor both arms of all paradoxes to move to a higher level of competence. For example, a competent accrediting body must honor both arms of the lumper/splitter paradox. Naming the competencies requires lumping; measuring them requires splitting. The ACGME sets standards for and accredits more than 120 specialties and subspecialties, each requiring very different skills, yet we wanted to foster conversations that cut across specialty lines and invite input from all physicians. We wanted this to be a professionwide conversation, not simply 120-plus different conversations. We wanted the conversation to belong to everyone. Yet measuring competence requires that representative particular behaviors be examined in fine detail, behaviors that are quite different across the various specialties. We had to aggressively lump and aggressively split the phenomena to take competence seriously.

   Consider the following example. Many are familiar with the "genius" resident who scores near perfect on every objective exam but cannot seem to tolerate the ambiguities associated with discerning the truth in the case of real patients. Likewise, some residents are gifted in social and conversational skills but lack the discipline and skill to be of real service to patients. Neither of these residents is competent. Competence requires that both arms of the art/science continuum be honored. Measurement tends to reward the first resident and punish the second, but instead, measurement should be used to inform a learning path forward for each.

3. Competence reduces fear and opens up space for joy. Fear is pervasive in healthcare. Patients and their families are understandably afraid; healthcare workers must overcome a natural tendency to turn and run away from human suffering. They must stand and directly face suffering and human vulnerability to be effective. Likewise, learners are terrified of either hurting patients or doing something that would make them appear incompetent. Fear taints all conversations in hospitals and other healthcare settings. It is toxic. Truth and truth telling about competence reduces fear. Thomas Merton once said, "We exhaust ourselves supporting our illusions."[2] Doing the work of patient care is hard enough; it is truly exhausting to both do the work and maintain false illusions/delusions of competence. My life changed when I began to tell patients

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that, “Hospitals can be dangerous places; bad things occasionally happen. Everyone has to be vigilant. I will try to be vigilant, but I also need you to be vigilant. Please let me know if you see anything out of the ordinary.” Each time I rounded I would ask them how they were doing, as well as how we were doing. It opened up a partnership that both enhanced safety and enabled guarded territory to see sunlight. Properly done, the work of healthcare is noble work. Helping each other in our weakness is as good as humans get. When done well, caring for patients enables joy to emerge even in the dreariest of places and circumstances. I believe that the ultimate measure of success in the competency movement is better patient care and that better patient care nourishes and permits a deep satisfaction to emerge in both patients and their caregivers. When we get it right, joy will return to the workplace.

4. It’s best to work with, not against, human nature. All humans come equipped with three faculties useful in the work of medicine: the intellect, the will, and the imagination. The object of the intellect is truth; that of the will is goodness; and that of the imagination is beauty or harmony. In the case of healthcare, this translates into three reflections. At the end of every day, we should all ask ourselves (and occasionally others): “How good a job did I do discerning and telling the truth?” “How good a job did I do putting what is good for the patient above my own interest?” “How good a job did I do harmonizing the best science and art—harmonizing the best scientific knowledge with a deep understanding of the patient in ways that informed and made my clinical decisions creative and marked by the practical wisdom inherent in good medicine?” Disciplined reflection on these three questions opens a path to competence.

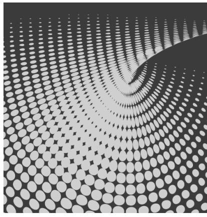
These four lessons also apply to those who teach, assess, and lead educational programs. Individual and communal reflection on experience, tolerance of paradox, overcoming fear of change by truth telling, and working with the intellect, will, and imagination all foster the emergence of competent institutions and educational communities.

I close by congratulating the authors of the chapters in this book. They have taken competence seriously and have provided a solid framework for ongoing community conversations about competence. Community leads to clarity and clarity leads to courage, the courage needed to carry the movement to the next level.

References

1. Dreyfus, H. On the Internet, Routledge Press, 2001. Hubert and Stuart Dreyfus are brothers (Hubert is a philosopher and Stuart a mathematician) both at UC Berkley. This book summarizes their elegant and extremely practical approach to the acquisition of skills by humans. Chapter 2, pp. 28–49, is especially relevant but the entire book is well worth while.

2 Merton, Thomas. Lectures to Novices, Credence cassettes. Credence cassettes has published an extensive series of audiotapes recording the voice of Thomas Merton lecturing the novices at Gethsemani when he was novice master. The tapes were never intended to be distributed beyond the walls of the monastery but contain many rich observations useful to lay people.



Preface

Welcome to the second edition of *A Practical Guide to Teaching and Assessing the ACGME Core Competencies*. In order to receive accreditation from the Accreditation Council for Graduate Medical Education (ACGME), residency programs must assess and document resident performance in the core competencies: interpersonal and communication skills, medical knowledge, patient care, practice-based learning and improvement, systems-based practice, and professionalism.

This book is intended for a wide audience as medical organizations and regulatory bodies worldwide use the same or similar competencies for physicians at all levels. In the United States, many medical schools, specialty and licensing boards, and medical accreditation organizations, including the American Board of Medical Specialties, the Federation of State Medical Boards, The Joint Commission, and others, have adopted these competencies.

A Practical Guide to Teaching and Assessing the ACGME Core Competencies, Second Edition, provides the research background, evidence-base, curricular models, teaching methods, assessment strategies, and faculty development suggestions for all six core competencies. In addition, you will find a number of assessment tools, many studied and validated, for evaluation and documentation. Many are also available online via the link included in this book.

We have substantially revised and updated the entire book to keep pace with changes in medical education and competency requirements. All chapters contain new perspectives, information, and resources. Some chapters have new or additional authors, all well-respected experts in medical education and in their chapter content. With growing recognition of the learning environment and its significant effect on medical education and organizational culture, we've added a new chapter on the hidden curriculum written by Fred Hafferty, PhD.

This second edition includes new curricular models, innovative teaching strategies, and new or updated assessment methods and tools for each competency. David C. Leach, MD, former executive director of the ACGME, provides a lively and wise perspective in the Foreword for this edition.

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We would like to thank Gary Smith, EdD, for his two chapters in the first edition. They have laid the foundation for the second edition chapters on those topics. We appreciate the new chapter authors who graciously and expeditiously gave of their time and expertise. A special thank you to Julie McCoy, our editor for the second edition, for her patience, good nature, and skillful editing.

Our "hidden curriculum" for the book is to promote relationship-centered teaching and learning, reflection, compassion, strong values, and careful consideration of how we can help develop reflective physicians who have a strong foundation of knowledge along with excellent clinical reasoning capabilities, lifelong learning skills, and the capacity to engage in mindful and caring relationships with their patients and colleagues. We hope this book will provide inspiration, guidance, and practical advice as you develop educational opportunities for your learners and faculty alike.

"Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it's the only thing that ever has."
—Margaret Mead

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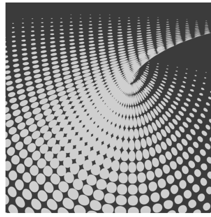

Graduate Medical Education: Making the Implicit Explicit

Sylvia R. Cruess, MD
Richard L. Cruess, MD

"The challenge for professional education is how to teach the complex ensemble of analytic thinking, skillful practice, and wise judgment upon which each profession rests."[1]

The relationship between medicine and society has undergone a profound transformation during the past decades. As one observer has noted, "the professionals' autonomy is severely restricted by budgets, bureaucracy, guidelines and peer review" while, at the same time, "a better informed community is asking for accountability, transparency, and sound professional standards."[2]

There is evidence that neither physicians nor society is entirely content with the current situation. Surveys of physicians have indicated substantial dissatisfaction with the contemporary practice of medicine.[3, 4, 5] Patients' satisfaction with their individual physicians remains high, but trust in the profession as a whole has diminished.[6, 7]

Although many factors have led to the current situation, a few require special attention in a discussion of the graduate education of physicians. First, the effectiveness of modern healthcare has made it essential to the well-being of citizens if they are to lead healthy and productive lives.[8] For this reason, the education and training of the modern medical workforce has become important to contemporary society.

Second, the impact of technology and the related subspecialization of medicine have threatened to turn physicians into technocrats rather than the healers who have served society for millennia. Neither society nor the medical profession wishes for this to occur.[9, 10]

Third, there is a belief that organized medicine and individual physicians have failed to meet some of the obligations expected of them as professionals.[1, 11] They are perceived as pursuing their own self-interest rather

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than demonstrating altruism, and it is believed that their commitment to self-regulation has been flawed. Thus, there is now a need for more explicit guidelines in teaching what is expected of a physician in today's world.

Finally, the structure of contemporary healthcare systems throughout the world has posed threats to the value system of medicine everywhere.[9] As either governments or commercial organizations became the principal third-party payers, they have tended to regard medicine as a commodity rather than a moral endeavor. Again, medical educators have concluded that if the values that have been the foundation of the practice of medicine for generations are to survive, they must be taught explicitly and reinforced throughout the continuum of medical education.[12, 13, 14]

As a result of these pressures, medicine's institutions—including licensing and certifying bodies, as well as educational and training establishments—have determined that it is necessary to address the aspects of medicine that are under their direct control. As a part of this process, there has been a serious reexamination of undergraduate medical education, graduate education and training, and the credentialing of physicians, including licensure, certification, and maintenance of competence. In graduate education, this has led to an analysis of the component parts of being a physician, which have been called "competencies," and to an effort to address each component during the course of training.[15]

Competencies: Definition and History

Many organizations within the healthcare field began efforts to better define competency in the 1970s, and at that time there were attempts to base educational programs on this concept.[16, 17] Although these activities certainly had an impact, it was not until they were applied at the graduate level that their potential became apparent. Virtually every organization concerned with graduate education in medicine expressed dissatisfaction with the methods used,[18] and a consensus developed that the practice of medicine needed to be divided into its component parts and that each component should be explicitly taught and the results evaluated.

If one looks at the evolution of medical education over the past 250 years, this seems to be a next logical step. Medical education in the eighteenth and early nineteenth centuries took place in apprenticeship-like settings.[18, 19] The development of structured curricula based on science represented an early and important step in addressing the increasing complexity of medicine.[20] However, graduate medical education continued to resemble an apprenticeship until a few decades ago, when attempts were made to improve its educational content. The development of the concept of competencies continues this trend, making the objectives and standards more explicit.

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As is true of so many aspects of the practice of medicine, dictionary definitions do not completely describe the meaning that medicine ascribes to competency. Epstein and Hundert have defined competence in medicine as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individuals and communities being served."[21] This accurately describes the aspects of the practice of medicine that are the subject of this book.

The history of the concept of medicine as constituting a group of competencies is instructive. In one major initiative, it started, appropriately, with an analysis of what patients wish to find in their physicians. In the 1980s, a study was carried out in Ontario, Canada, titled "Educating Future Physicians for Ontario" (EFPO).[22] An important component to this study was a series of focus groups involving patients who outlined what they expected from their physicians. The Royal College of Physicians and Surgeons of Canada (the organization responsible for certifying all specialists in medicine in Canada) took the results and developed the concept of "competencies" at the postgraduate level. They proposed that the object of graduate training is to turn out a medical expert (the central role) who will demonstrate the following competencies: communicator, collaborator, health advocate, manager, scholar, and professional.[23] Since 1996, graduate medical education in Canada has been structured around this framework, and this model (CanMEDS) has been used by several countries, including Australia and the Netherlands.

The Accreditation Council for Graduate Medical Education (ACGME) adopted the principle of competency-based graduate medical education and developed its own list of general competencies which form the basis of this book: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. These were implemented in 2001, and at the time of this writing all accredited residency programs in the United States must ensure that each competency is actively taught and that its residents are evaluated in each.[15, 22]

Although the ACGME only has jurisdiction over residency education, the impact of this concept has affected other educational levels as well. The Joint Commission, which provides accreditation to U.S. hospitals and other facilities, has adapted the core competencies as evaluation and recertification standards for medical staff members. Additionally, there was a movement toward competency-based undergraduate education[16, 17] which recently has been given added impetus. Two major studies, one in the United States[25] and the other in Canada[26], have strongly recommended that a competency-based curriculum serve as the model for undergraduate medical education. Many faculties of medicine have already moved in this direction, and it can be anticipated that more will follow.

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Challenges

Osler described medicine as "a calling in which your heart will be exercised equally with your head."[27] The challenge for medical education is to address both the head and the heart. Without question, this is true of attempting to teach the competencies.

Reaching the head requires that students master the cognitive base of each competency. For this to occur, shared learning objectives must be developed for each competency, and these must be understood by both teachers and learners. It seems to us that a structured program that ensures that all of the material is actually covered is the best way to achieve this.

However, if one reaches only the head, it is unlikely that much of what has been acquired will actually be put into practice. Professional identity arises "from a long-term combination of experience and reflection on experience."[28] A major objective of medical education should be to provide stage-appropriate education and training opportunities for both gaining experience in each competency and reflecting on it. The knowledge gained becomes part of a larger body of knowledge described as "tacit": that which one knows but has difficulty in telling.[29] Although tacit knowledge is difficult to teach, it can be learned, and situated learning,[30] which encourages self-reflection and promotes "mindfulness"[31] or "reflective practice,"[32] facilitates this process.

One can reach neither the head nor the heart unless the environment in which learning takes place is supportive. Hafferty has pointed out that the curriculum is more complex than it appears.[33, 34] There is the "formal curriculum" that is outlined in mission statements and course objectives, detailing what the faculty believe they are teaching. There is also a powerful "informal curriculum" at work, consisting of unscripted, unplanned, and highly interpersonal forms of teaching and learning that take place among and between faculty and students. Role models at several levels, from peers to senior physicians, function in the informal curriculum and can have a profound effect for good or ill.[35]

Finally, there is a set of influences that are largely hidden, functioning at the level of the organizational culture and structure. The influence of this "hidden curriculum" on teaching and learning can, like role models, be either positive or negative. Without question, the hidden and informal curricula form the background against which competency-based teaching and learning takes place. If these curricula are not supportive of the program, it is difficult to meet the desired objectives.[34]

Evaluation of the results of teaching the competencies presents a challenge, partly because competency-based education is a relatively new concept. There are tested tools for evaluating knowledge and skills, and these must

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be used.[36] However, attitudes and values cannot be evaluated in a reliable and valid fashion. Only observable behaviors that reflect these attitudes and values can be evaluated, and at the time of this writing very few evaluation tools are available to accomplish this.[21, 37] Therefore, the challenge is to develop reliable and reproducible evaluation methods as quickly as possible. Finally, the neglected field of remediation for underperforming students, residents, or practitioners must receive some attention.[38] At the present time, methods are available for remediation of gaps in knowledge and skills, but not for behaviors.

In addition, programs of competency-based graduate medical education must themselves be evaluated in a rigorous fashion. As a self-regulating profession, medicine enjoys the privilege of setting and maintaining standards for education and practice.[39, 40] Therefore, it has a societal obligation to ensure that physicians leaving their residency programs meet "sound professional standards." This will require long-term follow-up of residents in their practice.

Role Models and Faculty Development

For generations, respected role models were the principal means of transmitting knowledge, skills, and, most importantly, the values of the profession. Role models were and are capable of reaching both the head and the heart. Although the restructuring of graduate medical education represents recognition that role models alone are not sufficient to reliably produce a contemporary physician, they remain absolutely essential to the process.

Role models are the most potent means of transmitting those intangibles that have been called the art of medicine.[41, 42, 43, 45] They facilitate the development of a sense of collegiality in which students and residents acquire a sense of "belonging."[46] Conversely, negative role models can be extremely destructive, impeding professional development. Their negative influence posed difficulties before competency-based education was developed, and will certainly continue to do so unless the issue is addressed explicitly. Faculty development can assist in cultivating more effective role models, in part by ensuring that all faculty members understand the competencies and "speak the same language."[47] Removing physicians who constitute a negative influence on students, residents, and peers is also essential.

Some caveats must be mentioned. The first relates to professionalism, a competency which is fundamental to medical practice and which serves as the basis of medicine's social contract with society.[11] Legitimate doubts have been raised as to whether professionalism is a competency which is more than mere expertise. It has been suggested that professionalism represents medicine's moral base, not just expertise, and there are questions as to whether morality can be taught.[48] Without question, this is one reason teaching and assessing professionalism has posed special problems that have not yet been completely solved, particularly at the postgraduate level.

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Second, medicine's competencies overlap with those found in other health professions, and the current need for team medicine appears to dictate that some attention must be paid to integrating medical education with the education of other health professionals.[49, 50] Third, and linked to the preceding point, the competency movement stresses, as it must, the development of competencies in individual physicians. The future will certainly see an increased emphasis on team performance rather than individual performance. This will require the use of educational methods that encourage collective competence through "distributed knowing" and knowledge-building communities.[51]

A final point must be made. Competency-based graduate education divides the practice of medicine and the medical act into a series of separate domains. However, this does not reflect what physicians do in the presence of their patients. These domains must be reintegrated into a seamless whole, and this can be done only by individual physicians as they gain experiential knowledge. Postgraduate programs, in addition to teaching the competencies explicitly and providing opportunities for experiential learning, are responsible for ensuring that this reintegration takes place. It appears to us that assisting in this essential task may represent the most important function of the role models of the future.

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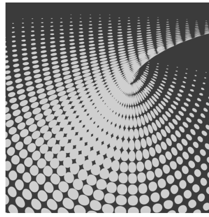
CHAPTER 6



Professionalism

Elizabeth A. Rider, MSW, MD, FAAP

The most important problem for the future of professionalism is neither economic nor structural but cultural and ideological. The most important problem is its soul.

—Eliot Freidson, PhD[1]

Introduction

Physicians, patients, and society would agree that professionalism is valuable, important, and essential to medicine, and that unprofessional behavior is unacceptable. Yet requirements for teaching and assessing professionalism present medical educators with many challenges. Professionalism has been hard to define, and even harder to assess.

Interest in improving professionalism curricula in residency programs and medical schools has existed for several decades. Since the 1980s, the medical profession has demonstrated a sustained commitment to advancing professionalism.

Medical regulatory and accrediting organizations worldwide require physician competency in professionalism, and a number of these organizations have developed initiatives to define and measure professionalism. The emphasis on professionalism at all levels of training is reflected in guidelines for medical schools (the Liaison Committee on Medical Education [LCME],[2] Association of American Medical Colleges [AAMC],[3] Institute for International Medical Education,[4] and General Medical Council[5]) and graduate and postgraduate certification standards (ACGME,[6] United States Medical Licensing Examination,[7] Royal College of Physicians and Surgeons of Canada,[8] Confederation of Postgraduate Medical Education Councils in Australia,[9] General Medical Council, UK,[10] Educational Commission for Foreign Medical Graduates,[11] and American Board of Medical Specialties [ABMS]). In 1999, the ACGME endorsed professionalism as one of six general competencies postgraduate residents should demonstrate. The ABMS, the Federation of State Medical Boards,[12] and The Joint Commission[13] have adopted the same competencies for practicing physicians.

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Various professional societies[14, 15] have addressed the need to examine and promote professionalism in medicine. The American Board of Internal Medicine has been a leader in this realm, beginning with its Project Humanism in the 1980s and continuing with its focus on Project Professionalism in the 1990s and the development of a Physician Charter[16] in medical professionalism in collaboration with the American College of Physicians, the American Society of Internal Medicine, and the European Federation of Internal Medicine. The Physician Charter has been adopted by the ACGME, all specialties of the ABMS, and physician organizations throughout the world.[17]

Professionalism in healthcare: How are we doing?

> "You are in this profession as a calling, not as a business; as a calling which exacts from you at every turn self-sacrifice, devotion, love and tenderness to your fellow men. Once you get down to a purely business level, your influence is gone and the true light of your life is dimmed. You must work in the missionary spirit, with a breadth of charity that raises you far above the petty jealousies of life."
>
> —Sir William Osler, MD[18]

Problems exist with the professional and ethical behavior of physicians and other healthcare professionals. Ludmerer[19] notes an increase in public concerns that physicians are impersonal, self-serving, and sometimes dishonest. The media often report professional transgressions by physicians. Studies show that many patient complaints about physicians involve unprofessional behavior, and that patients are more likely to sue physicians they perceive as behaving unprofessionally.[20] However, we know that a small number of physicians generate a disproportionate number of complaints.[20]

How will we develop our learners as professionals, and identify and remediate the few whose impaired professionalism ultimately erodes the trust the public has in physicians? Consideration of the threats to professionalism is important in determining issues facing learners and physicians today.

The stakes are high. Regarding society's expectations of physicians, Jordan J. Cohen, MD,[21] President Emeritus of the AAMC, notes:

> *"Failing to deliver on these expectation, that is, falling short on the responsibilities of professionalism will surely result in a withdrawal of the tremendous advantages that now accompany our profession's status."*

Threats to professionalism in medicine

> "Physicians are jumpy, living with … third- party pressures on what they do or do not do, and with the current conventional wisdom that patient care is some sort of impersonal commodity to be bartered at the cheapest price in the marketplace."
>
> —Malcolm S. M. Watts, MD[22]

Medicine faces myriad threats to professionalism. As a profession, medicine is under extraordinary scrutiny resulting from changes in working patterns, increased

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public concerns and expectations, loss of control over the medical marketplace (which is now largely controlled by the corporate sector and the state), and subsequent market forces that have led to commercialism and the corporate transformation of medicine.[23]

Howland notes that physicians are more often employed by or dependent on organizations with "… a business ethic that is indifferent and occasionally hostile to the values and behaviors of professionalism."[(p. 639) 24] Lundberg concurs: "The fundamental purpose of a business is to make money. … On the other hand, the fundamental purpose of a profession is to provide a service that reflects commitment to a worthy cause that transcends self-interest."[(p. 1541) 25]

Hafferty, Cohen,[26] and others describe the enemies of professionalism as commercialism and self-interest. Hafferty notes:

> *Today, physicians who transform biomedical discoveries into marketable products and then bring those products to Wall Street are the new heroes of academic medicine. Faculty are urged (with salary and pay raises on the line) to adopt a more entrepreneurial orientation toward their work.*[27]

Commercialism continues to thrive within clinical and research medicine, although efforts for transparency and disclosure of conflicts of interest are beginning to gain ground. Even with organized medicine's work to enhance and reinvigorate medical professionalism, only recently has there been more focus on professionalism by state medical boards.[28] Much work remains.

> *If medical students are to internalize the "true meanings" of professionalism, then organized medicine will need to rid the streets (as best as possible) of these commercial enticements, for this is where our students go (and learn) after classes end and after their teachers have retired for the evening.*[27]

Part of medicine's social contract is its promise to police itself in the public interest.[29] Hafferty recommends that organized medicine implement a meaningful and public system of peer review—with attention to commercialism and self-interest—so that the public will know that professionalism remains sacrosanct.[27]

Why teach professionalism?

> "Medicine is a moral community, the practice of medicine a moral undertaking, and professionalism is a moral commitment."
>
> —Frederic Hafferty, PhD[30]

All levels of medical education need to give attention to teaching and promoting professionalism. Professionalism is not sufficiently learned during medical school and residency training, though many programs are working to improve in this area.

Numerous reasons exist for developing a strong curriculum in professionalism. First, professionalism forms the basis of a social contract between medicine and society. Additional reasons to teach and assess professionalism include the association of professionalism in physicians with improved medical outcomes and of unprofessional behavior with adverse medical

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outcomes, ethical issues that affect the moral development of physicians, and patient and societal expectations. As noted earlier in this chapter, accreditation organizations require professionalism training throughout medical education.

Professionalism as a social contract

"Professionalism has come to serve as the basis of medicine's social contract."
—Sylvia R. Cruess, MD[31]

Cruess and Cruess[32] assert that professional status is not an intrinsic right but is granted by society. The continuation of professional status depends on the public's belief that professionals are trustworthy, and professionals must meet the obligations expected by society in order to remain trustworthy.[32] Stern and Papadakis note:

> *"What is at stake is nothing less than the privilege of autonomy in our interactions with patients, self-regulation, public esteem, and a rewarding and well-compensated career."*[33]

Trust between the physician and the patient is primary, and healing is put at risk without this trust. The social contract functions only if both sides, physician and society, have reasonable expectations of each other. Figure 6.1 presents the expectations of medicine and society in the social contract.

Figure 6.1 **The Social Contract Between Medicine and Society**

Society's Expectations of Medicine	Medicine's Expectations of Society
• Services of the healer • Assured competence • Altruistic service • Morality and integrity • Accountability • Transparency • Source of objective advice • Promotion of the public good	• Trust • Autonomy • Self-regulation • Value-driven and adequately funded healthcare system • Participation in public policy • Shared (patients and society) responsibility for health • Monopoly • Status and rewards – Non-financial: respect and status – Financial

Source: Cruess SR. Professionalism and medicine's social contract with society. Clin Orthop Relat Res. *2006;449: 170–176. Reprinted with permission.*

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Medical educators and others involved in medical training must ensure that future physicians understand the social contract, and are equipped to fulfill their responsibility of trustworthiness and to uphold the primacy of the patient's welfare.

Professionalism and outcomes

Studies demonstrate an association between physician excellence and professionalism.[34] Trust is a component of professionalism, and patients are more likely to adhere to treatment recommendations when they trust their physician.[35] Studies show that patients who perceive their physicians as behaving professionally are more satisfied and are more likely to remain with and recommend their physicians to others.[36]

Papadakis and colleagues[37] found that physicians who were disciplined by state medical licensing boards were three times more likely to have shown unprofessional behavior in medical school than those with no such disciplinary actions. The strongest association occurred with those described as irresponsible or as having diminished ability to improve their behavior. The authors stressed the importance of identifying students who display unprofessional behavior, and the risk that unprofessional behavior may persist over decades. Stern and colleagues[38] found that medical students who were unable to perceive their weaknesses and who lacked thoroughness during the first two years of medical school were more likely to show unprofessional behavior during the clinical years. More recently, Papadakis and colleagues,[39] in a study of 66,000 internists, found that low professionalism ratings during residency resulted in significantly greater risk for future state licensing board actions. These studies provide empirical evidence for focusing on professionalism as a core competency in medical education.

Public concern about medical ethics has led many medical schools to increase their formal teaching of ethics, a significant component of professionalism. Hicks and colleagues[40] studied 108 medical students and found that nearly half had felt pressure to act unethically and 61% had witnessed a clinical teacher acting unethically. The medical students encountered three types of situations:

- Conflict between the priorities of medical education and patient care
- Responsibility exceeding a student's abilities
- Perception of involvement in patient care thought to be substandard

Notably, the ethical problems encountered were rarely discussed or resolved with clinical teachers. This study underscores the importance not only of teaching professionalism, but also of developing robust faculty development programs for this competency.

Definitions of Professionalism

"Character is doing what's right when nobody is looking."
—JC Watts, Congressman, 1996

Medical professionalism has proven difficult to define. There is no consensus on a universal definition of professionalism in medicine, yet many similarities exist among conceptual frameworks and descriptions.

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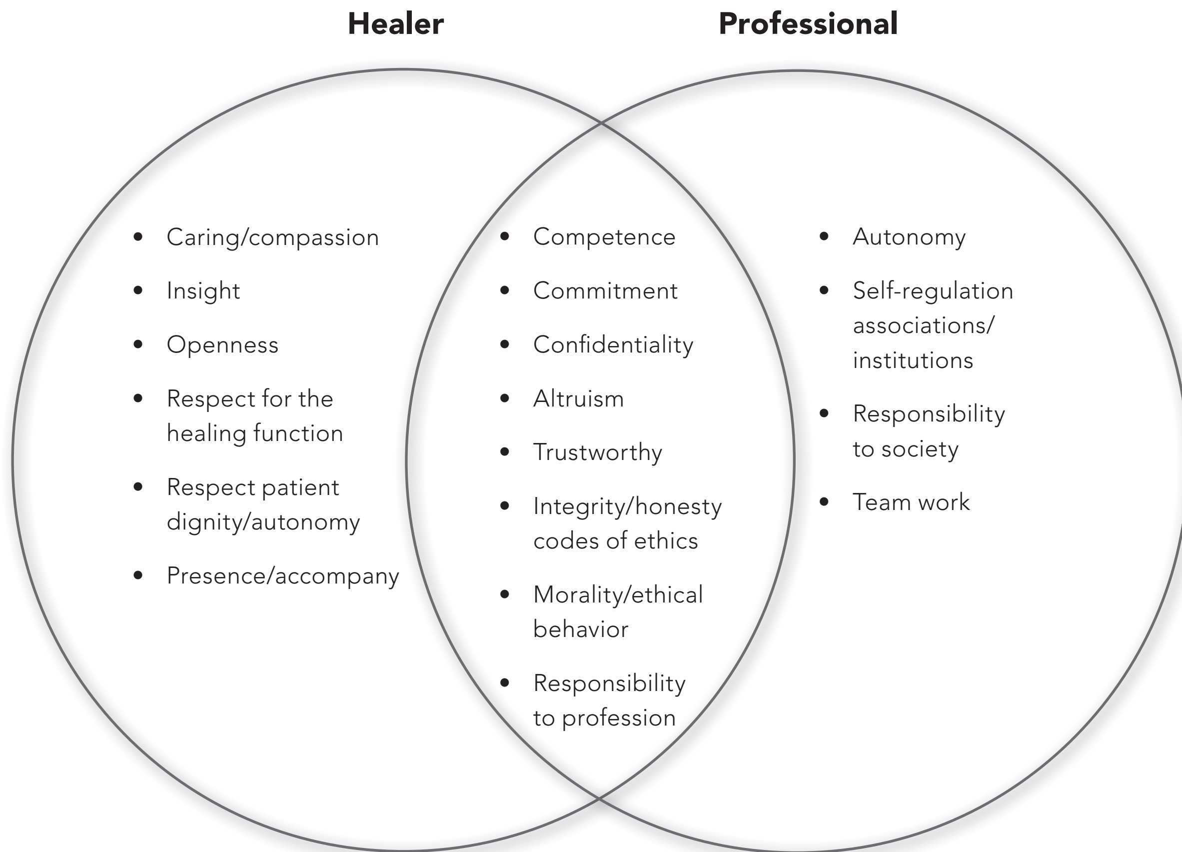
In addition to the social contract between medicine and society, Cruess and Cruess[41] propose that the physician fills two roles in society: those of healer and professional. They identify attributes of both the healer and professional roles, and the attributes common to both (see Figure 6.2). Cruess and Cruess recommend that faculty members direct careful attention to the teaching of both roles: "… great care must be taken to include all aspects of both roles as the definition dictates not only what is taught but also what will be evaluated."[(p. 14) 41] They also note that society needs the services of the healer, and that the professionalism taught must provide a moral foundation for future physicians whose duty is to make certain that "… both the role and the values of the healer survive."[(p. 14) 41]

Figure 6.2 **Attributes of the Physician as Healer and Professional**



Source: Cruess SR, Cruess RL. The cognitive base of professionalism. In: Cruess RL, Cruess SR, Steinert Y (eds). Teaching Medical Professionalism. *Cambridge, UK: Cambridge University Press, 2009, p. 13. Reprinted with permission.*

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Various organizations have put forth definitions of professionalism (see Figure 6.3). Inui[42] notes that definitions of professionalism provide descriptions of how a virtuous physician would act. He advises medical educators to choose a definition and take it seriously, and to consider how learners can come to understand and exemplify these qualities.

Figure 6.3

Selected Definitions of Professionalism

ACGME Definition of Professionalism[43]

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

1. Compassion, integrity, and respect for others
2. Responsiveness to patient needs that supersedes self-interest
3. Respect for patient privacy and autonomy
4. Accountability to patients, society, and the profession
5. Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation

A Physician Charter (ABIM, ACP, EFIM)[16]

Fundamental principles:

- Principle of primacy of patient welfare
- Principle of patient autonomy
- Principle of social justice

The charter outlines 10 professional responsibilities, which include a commitment to:

1. Professional competence
2. Honesty with patients
3. Patient confidentiality
4. Maintaining appropriate relations with patients
5. Improving quality of care
6. Improving access to care

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Figure 6.3

Selected Definitions of Professionalism (cont.)

7. Just distribution of finite resources
8. Scientific knowledge
9. Maintaining trust by managing conflicts of interest
10. Professional responsibilities

The duties of a doctor registered with the General Medical Council, UK[44]

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
  - Keep your professional knowledge and skills up to date
  - Recognize and work within the limits of your competence
  - Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
  - Treat patients politely and considerately
  - Respect patients' right to confidentiality
- Work in partnership with patients
  - Listen to patients and respond to their concerns and preferences
  - Give patients the information they want or need in a way they can understand
  - Respect patients' right to reach decisions with you about their treatment and care
  - Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
  - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk

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Figure 6.3

Selected Definitions of Professionalism (cont.)

- Never discriminate unfairly against patients or colleagues
- Never abuse your patients' trust in you or the public's trust in the profession

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Professionalism in Pediatrics: Statement of Principles
Policy Statement: American Academy of Pediatrics[45]

Core professional principles and values that pediatricians and pediatric subspecialists, including trainees, should embrace and that provide an ethical foundation for quality healthcare for children and their families:

Principles

- Honesty and integrity
- Reliability and responsibility
- Respect for others
- Compassion/empathy
- Self-improvement
- Self-awareness/knowledge of limits
- Communication and collaboration
- Altruism and advocacy

Values

- Responsibilities to patients and families
- Responsibilities to other health professionals and healthcare and support services providers
- Responsibilities to communities
- Responsibilities to the profession

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What constitutes unprofessional behavior?

Papadakis and colleagues[37] found that the types of unprofessional behavior most strongly associated with disciplinary action by state medical boards were severe irresponsibility and significantly diminished capacity for self-improvement. Examples of unprofessional behavior abound. Duff[46] cites the following:

- Intellectual or personal dishonesty
- Arrogance and disrespectfulness
- Prejudice
- Abrasive interactions with patients and coworkers
- Lack of accountability for medical errors and administrative oversights, including when "… the student or physician fails to demonstrate sufficient personal investment in the patient's outcome"
- Fiscal irresponsibility, including ordering clinically unnecessary tests and accepting kickbacks
- Lack of sustained commitment to self-learning
- Lack of due diligence
- Personal excesses, including substance abuse and high-risk behavior
- Sexual misconduct

Building a Curriculum for Professionalism

> "Healing is the mandate of medicine, and professionalism is how it is organized."
>
> —Sylvia Cruess, MD[47]

The complexity of professionalism in medicine presents a challenge to educators seeking to teach and evaluate this competency. We know that physicians do not acquire professionalism via their upbringing, osmosis, academic coursework, one or two workshops during training, or other short-lived interventions. Instead, medical educators and leaders must explicitly define, clarify, teach, and model the values and capacities we expect physicians to learn and exhibit, and faculty role models must have a thorough knowledge of professionalism.

Designing curricula for professionalism requires attention to its various components, including the knowledge base of professionalism (i.e., the social contract and roles and attributes of both the healer and the professional), presented previously; the moral and ethical development of learners and faculty members; authenticity; and the learning environment, including the hidden curriculum (HC) and organizational culture.

Professionalism and moral reasoning

Moral reasoning and judgment are essential components of professional behavior, and they apply to both the awareness of moral issues and the demonstration of appropriate moral actions in medical education and clinical care.[48] Bebeau[49] found that education in the health professions did not promote moral judgment,

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but that the addition of ethics instruction increased moral reasoning and judgment. Self and Baldwin[50] documented a significant positive relationship between levels of moral reasoning and measures of clinical excellence in medical students, residents, and practicing physicians. In a study of malpractice claims against orthopedic surgeons, Baldwin and colleagues[51] discovered that orthopedists in the low-claims group had significantly higher levels of moral reasoning than orthopedists in the high-claims group.

It appears that medical education may profoundly influence moral development. Feudtner and colleagues[52] describe the "ethical erosion" reported by medical students. Patenaude et al.[53] presented striking results from their study: Entering medical students used higher-stage moral reasoning orientations than the same students at the end of their third year. Residents also fail to make age-expected growth in moral reasoning abilities during their training.[54]

A disconnect exists between the professed values of medicine and the actual practice that learners observe, making it hard for them to determine what values to learn, and resulting in increased stress, burnout, isolation, loss of empathy,[55, 56] ethical erosion,[52] and a stunting of moral development.[57] According to Rabow and colleagues, "When physicians are distanced from themselves and from such values as honesty and altruism, patient safety may suffer."[(p. 312) 58]

It appears that socialization into medical culture comes at a high price. Consequently, those involved in medical education must work to promote the moral development of their learners.

The moral and ethical development of learners and faculty

"Medicine, after all, is a moral profession."
—William Branch, Jr., MD[57]

Professionalism and the moral and ethical development of learners and faculty are inextricably entwined. Most learners are in their early adulthood, a time of significant moral development and attitudinal change.[59] Moral development is a lifelong task, and faculty members also continue to develop morally.

Burack and colleagues[60] studied attending physicians' responses to residents' and medical students' problematic behaviors on the wards—that is, showing disrespect for patients, cutting corners, and exhibiting outright hostility or rudeness. They found that attending physicians did not respond to problematic behaviors in any observable way and they let the majority of incidents pass without comment. In a minority of cases when attending physicians did respond, their feedback was subtle and often misinterpreted or unnoticed by learners.

Regarding Burack and colleagues' findings, Branch[57] notes that attending physicians' responses may play down the moral aspects of the trainees' behavior. He draws an association between the learners' dilemma (maintaining caring attitudes versus suppressing their moral principles to function on the clinical team) and faculty members failing to respond to the poor ethical behavior of their learners. Any curriculum for professionalism requires attention to the moral development of both learners and faculty.

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Professionalism and authenticity

Coulehan draws a distinction between professional etiquette and professional virtue, noting "… if we focus on the former and pay only lip service to the latter, we have nothing but window dressing."[61] Hafferty concurs, and asserts that being a physician and "taking on the identity of a true professional" involves more than knowledge, skills, and outward behavior.[30]

> *"There is a meaningful (and measurable) difference between being a professional and acting professionally. … [W]e must attend to such inconsistencies between the inner self and outward appearance, sending a message that authenticity is a matter of great concern."*[30]

Boudreau and colleagues emphasize that for effective healing, "… it is not only what the healer 'does' that is important, but also who the healer 'is.' "[(p. 7) 62]

Value orientations and commitment to learning, excellence, and genuinely caring behavior and practices remain primary.

Educating for professionalism: The hidden curriculum and organizational culture

> "No matter how much we write about professionalism's importance, or plan its inclusion into undergraduate or postgraduate curricula, it is the day-to-day experience of working within a clinical environment that will be most influential in its development."
>
> —Sean Hilton, MD, FRCGP[63]

Attention to the learning environment, including the HC and organizational culture, is essential to the teaching and learning of professionalism. The social and organizational environments of training institutions have a profound influence on professional identity formation. To improve professionalism education, we need to bring the formal curriculum and its moral, ethical, and humane values into alignment with the HC so that the HC consistently models these values. (For more on these issues, please see Chapters 1 and 7.)

The hidden curriculum and the culture of learning

> ". . . outside the courses lies the 'hidden curriculum,' the students' exposure to what we actually do in our day-to-day work with patients and one another—not what we say should be done when we stand behind podiums in lecture halls."
>
> —Thomas Inui, ScM, MD[42]

The HC, described as "… the unofficial rules for survival and advancement,"[64] results in pressure to conform and a focus on pleasing superiors, sometimes at the patient's expense.

> "The physician's attitudes, mindset, moral stance, and the hour-by-hour decisions about how to use one's time—all these and many other matters, even including how and what and how much to feel, are observed by the student and imitated assiduously."
>
> —Melvin Konner, MD[65]

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Role modeling has the most powerful influence on learners' understanding of professionalism.[42] Negative role modeling experienced during clinical training undermines the attitudinal messages of the formal curriculum. Learners internalize and perpetuate attitudes and behaviors of their role models,[66] and they feel caught between their moral principles and the pressures to suppress their moral principles to fit in with team members.[57]

The culture of medical education can erode learners' idealism and social consciousness. Coulehan and Williams[67] describe socializing phenomena that make it difficult to be a caring physician, including the development of detachment, a sense of entitlement, and a nonreflective professional practice. The authors note that, although medical education in the United States promotes a commitment to traditional values of doctoring—empathy, altruism, and others—a tacit belief exists that physicians best care for patients as "objects of technical services (medical care)."[67]

Coulehan describes three styles of professional identity that can manifest in young physicians as a result of conflicts between explicit and tacit values and the formal and hidden curricula:[68]

1. A technical professional identity in which physicians practice medicine according to the hospital culture, discard traditional values, and narrow their responsibility to the technical arena

2. A nonreflective professional identity in which physicians believe they exemplify traditional professional virtues yet act in ways that are in conflict with those virtues, and contribute to problems in healthcare (e.g., poor physician–patient communication and others)

3. A compassionate and responsive professional identity in which young physicians have overcome the conflict between explicit and tacit socialization[68]

Coulehan believes that a large percentage of graduates manifest a nonreflective professional identity.[68]

Reisman[64] describes learners' natural instincts against the HC as a "gift" that can remind faculty members to encourage students to:

- Share their experiences
- Teach that what they observe might not always be the correct way to behave
- Affirm the learner's caring for, and desire to protect, the patient

Organizational approaches to fostering professionalism

> "Under present circumstances, students become cynical about the profession of medicine—indeed, may see cynicism as intrinsic to medicine—because they see us 'say one thing and do another.' … Additional courses on 'medical professionalism' are unlikely to fundamentally alter this regrettable circumstance. Instead, we will actually have to change our behaviors, our institutions, and ourselves."
>
> —Thomas Inui, ScM, MD[(p. 4–5) 42]

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Many believe that organizational change is a prerequisite to improving education for professionalism and for enhancing professionalism throughout healthcare institutions. How can we create institutionwide organizational change? First, professionalism needs to come up on the radar screen of institutional leaders and educators as an urgent focus, and then action for organizational change can follow.

To be effective, institution leaders and educators should design programs for systematic institutional implementation that guide and support professional development. Rider and Longmaid[69] note that interpersonal, communication, and management skills are critical for leaders of the change process, and that an awareness and understanding of systems issues and human factors increase the likelihood of success. They found that successful organizational change requires:

- Carefully planned and executed series of actions
- Effective communication on all levels
- Effective leadership
- An open process with stakeholder input
- Attention to institutional cultures
- Continuous involvement, input, and creation of the program by those most affected

Rider and Longmaid[69] propose steps that educators and organizational leaders can undertake to manage organizational and cultural change around institutional educational initiatives. Although their model was designed for residency program mergers, their guidelines also are relevant for organizational change efforts to enhance professionalism. They are:

1. Lead with vision
2. Establish and reinforce communication links early to maximize collaboration
3. Challenge everyone in the organization to think about and own the process of change
4. Acknowledge and consider different cultures and identify shared values
5. Start with a clean slate and respect each other
6. Develop mechanisms for and solicit stakeholder input
7. Listen to and learn from each other
8. Maintain equity and fairness
9. Delegate and empower teams for action[69]

In his seminal paper, “A Flag in the Wind: Educating for Professionalism in Medicine,” Inui[42] provides specific action agenda items for institutional change in order to promote professionalism education. He notes that not everything needs to change at once, and that small changes can lead to larger changes in the interconnected organizational network of academic healthcare institutions. The caveat, and necessary ingredient, is that institutional leaders facilitate and support change from the top. Chapter 1 presents additional strategies for organizational change, including appreciative inquiry and positive deviance.

Teaching Professionalism

"Another way of thinking about this work is formation; it leads one to think of shaping. Shaping by both internal and external forces and influences—how is this individual, from the inside out, going to develop values?"

—David C. Leach, MD[70]

Professionalism can be taught and learned.[14, 71, 72] In addition to teaching the knowledge or cognitive base[41] of professionalism—the roles and attributes of both the healer and the professional and the social contract between medicine and society—described previously in this chapter, we must focus on the learning environment and organizational culture as well as the moral and ethical development of learners and faculty. Teaching professionalism includes a careful focus on the learner–teacher relationship, the development and enhancement of reflection and self-awareness, and an understanding of professional boundaries. As teaching reflection is essential for the development of reflection in learners, specific strategies for teaching reflection are discussed, including role modeling, enhancing reflection through reflective feedback, developing mindfulness, narrative medicine and storytelling, and critical reflection groups.

The learner–teacher relationship

"Find out about who I am as a person, and give me a chance to learn more about you. Ask me about my learning goals, and invite me to plan with you how we will go about pursuing them. You are not only our teachers; you are our colleagues and our role models."

—Jodi Skiles, medical student[73]

Just as the physician–patient relationship forms the foundation of healthcare, the learner–teacher relationship forms the basis for the overall learning experience. The way teachers treat learners affects how trainees interact with patients and colleagues, and the extent to which teachers can foster development and learning.

Relationships are a significant mediating factor in the HC. Studies show that the learner–teacher relationship not only affects students' motivation to learn and the actual learning that occurs, but also impacts the learner's social identification.[74] The learner–teacher relationship, as it affects identity formation, can have a powerful influence on learners' professional behaviors and choices.[75] Chapter 1 also discusses the learner–teacher relationship.

Teaching strategies for developing the reflective physician

"… critical self-reflection enables physicians to listen attentively to patients' distress, recognize their own errors, refine their technical skills, make evidence-based decisions, and clarify their values so that they can act with compassion, technical competence, presence, and insight."

—Ronald Epstein, MD[76]

We know that reflection and self-awareness are necessary for the development of professionalism.[33, 58, 77, 78, 79, 80] The ability to reflect enables physicians to develop insight into interactions with patients and colleagues, enhances critical thinking, and is one factor that separates professionals from technicians. Reflective skills are associated with the ability to develop insight

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into one's self and one's learning needs, to direct one's learning, and, ultimately, to ensure that the physician can practice well autonomously.

Reflection merits specific attention and inclusion in medical education curricula. Studies show that residents do not know instinctively how to engage in systematic self-reflection,[81] and that psychological growth occurs only when reflection is part of professional education.[82]

Teaching about and modeling reflection and self-awareness promotes caring among learners and faculty. Branch[83] notes that the ethics of caring include:

- Preserving empathy and compassion—that is, receptivity—in learners
- Teaching learners to take responsibility for patients
- Ensuring an educational environment that values these attributes

Learning opportunities for reflection can occur individually, in one-on-one learning situations with a trusted teacher, and in small groups. An essential component of curricula for promoting reflection is the selection and training of faculty who are respectful of learners' needs, personally self-aware, and able to reflect.

Role modeling and reflection

"Help us to learn about healthy ways to cope with difficult patients, uncertainty, and other challenges of practicing medicine by sharing with us your own responses, questions, and doubts. If you have the courage to initiate conversations about these difficult situations, you will create a safe atmosphere in which all parties will learn—not only about medicine and science, but about patient care and compassion as well."

—Jodi Skiles, medical student[73]

Role modeling is often considered a primary strategy for teaching ethical and professional behavior, and it is at the heart of character formation.[84] Role modeling is a powerful teaching method for conveying the values, knowledge, and skills of the medical profession. Although individual attending physicians alone cannot change the cultural climate of the HC by serving as positive role models, they can affect the culture of their team and the team's attitude toward patients. Learners observe their teachers as role models—positive or negative—and role models teach by example 24/7.

Unfortunately, faculty can miss opportunities for positive role modeling, and they may sometimes serve as negative role models. Stern[85] observed interactions between teachers, residents, and patients and found that professional values such as caring, honesty, and accountability were barely discernible during teaching rounds. Additional professional values such as altruism, confidentiality, and "do no harm" were noticeably absent.

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Role models are "… individuals admired for their ways of being and acting as professionals."[86] Studies show that learners identified as excellent role models faculty members who:

- Love their work and are enthusiastic
- Stress the importance of the physician–patient relationship
- Teach psychosocial skills
- Have clinical skills and teaching abilities that are seen as highly competent[87]

Learners identify negative role models as those who:

- Are dissatisfied with their careers
- Have inadequate interpersonal interactions with patients and others[88]

Cruess, Cruess, and Steinert[89] note that learning from role models involves both unconscious and conscious processes and occurs through observation and reflection. Understanding both unconscious and conscious aspects is vital. The authors note:

> *Active reflection on the process can convert an unconscious feeling into conscious thought that can be translated into principles and action. In an equally powerful process, observed behaviors are unconsciously incorporated into the belief patterns and behaviors of the student.*[(p. 718) 89]

Figure 6.4 shows the mechanism by which the process of role modeling occurs.

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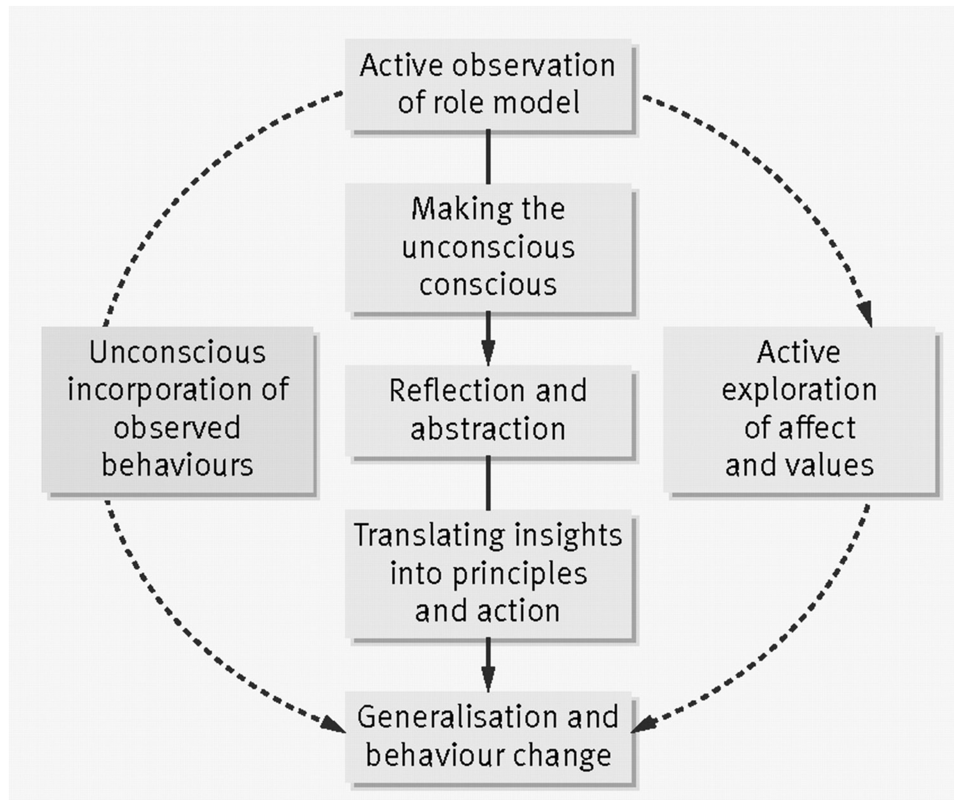
Figure 6.4

The Process of Role Modeling



Adpated from: Epstein RM, Cole DR, Gawinski BA, Piotrowski-Lee S, Ruddy NB. How students learn from community-based preceptors. Archives of Family Medicine 1998; 7:149–154 (p. 151) Reprinted in Cruess SR et al, BMJ 2008; 336: 718–721. Reprinted with permission.

Branch and colleagues[90] recommend enhancing role modeling and teaching of the human dimensions of care by actively involving residents and students in reflection and introspection and by taking advantage of seminal events to create memorable learning opportunities. They suggest teachers develop active learning methods, guided by the following questions:

- How can I foster broad participation in this activity?
- How can I foster a safe environment for learners to share their own fears, concerns, and dilemmas?
- What opportunities exist for practice, feedback, and discussion?
- What opportunities for reflection exist during this activity?[90]

Role modeling alone is an insufficient teaching strategy unless it is combined with reflection on actions.[91] Follow-up discussion and reflection on experiences are necessary for the effective teaching of professionalism. Figure 6.5 lists suggestions for role modeling with reflection.

Figure 6.5

Ground Rules for Role Modeling with Reflection

1. Explicitly call attention to what you are role modeling.
2. Explain what you have done and why.
3. Treat learners with the respect with which you expect them to treat patients.
4. Ask learners to reflect on their observations and experiences. "How did that go for you?" "What did you learn?"
5. Articulate and teach values. For example, tell learners that you value caring for the patient and showing respect and compassion, and why.
6. Provide perspective. Place learners' observations/experiences in the broader context of patient care.

Reflective feedback: A strategy for teaching and enhancing reflection

Both feedback and reflection are essential components of medical education. Although medical educators recognize the value of giving effective feedback about professional behaviors,[92] such feedback is more often espoused than practiced.[93, 94, 95] Training programs use written evaluation instruments for residents, yet minimal time is spent giving ongoing, face-to-face feedback.[93] Positive feedback about good professional behaviors and attitudes draws attention to these positive actions and increases the likelihood that they will be repeated and will endure. Good feedback teaches not only what should occur, but also why it should occur, and teaching why certain behaviors are important gets back to the values of professionalism.[96]

Rider and Hinrichs[97] developed a reflective feedback model for faculty teaching communication skills and professionalism at Harvard Medical School. Rider further expanded the model for teaching and faculty development.[98] The goal of reflective feedback is to teach and enhance reflective skills, self-awareness, and reflective practice. Reflective feedback occurs when the clinical teacher actively facilitates and models a process of reflection in the setting of giving feedback.[97, 98]

Reflective feedback can provide a focus for teaching professionalism, interpersonal and communication skills, critical thinking, and skills for lifelong learning. Figure 6.6 presents a model and guidelines for reflective feedback. The phrases are not a script, but rather ideas to use to develop your own style. Faculty can use the model in brief or in extended discussions about interactions with patients, colleagues, and teams, and for learning specific skills and procedures.

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Figure 6.6

Guidelines for Reflective Feedback: What to Do When You Only Have Five Minutes

1. **Establish rapport** with the learner. Show interest, respect, and caring throughout your interactions.

2. **Ask about learning goals** before the observed interview or brief observation.

   - *"What are your learning goals for this interview / interaction / procedure?"*
   - *"Is there anything, specifically, that you would like to work on?"*
   - *"While I observe you, is there an area you would like me to pay particular attention to?"*

3. **Facilitate reflection:** Invite the learner to share their reflections. Stimulate curiosity. Facilitate the discussion to **keep reflection on an insightful level,** rather than a series of intellectual observations.

   - *"How did the interview (or interaction or procedure) go for you?"*
     - **Note:** This is different than asking, *"How do you think you did?"*
   - *"What stood out for you?"*
   - *"What were your impressions?"*
   - *"Was there anything that you were curious about?"*
   - Encourage the learner to delve deeper: *"Anything else?"*

   Ask the learner what he or she did well.

   - *"What did you feel good about?"*
   - *"What did you learn?"*

   Explore areas for improvement.

   - *"What might you do differently next time?"*
   - *"What do you think needs improvement?"*

4. **Model reflection:** After the learner has shared their reflections and thoughts, share yours.

   Validate positive behaviors: Teach why particular behaviors / skills / attitudes are important for communication with patients (or for performing a particular skill or procedure) and how they help to build the physician-patient relationship and the learner's skills. Be specific and use non-judgmental language.

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Figure 6.6

Guidelines for Reflective Feedback: What to Do When You Only Have Five Minutes (cont.)

- *"After you validated the patient's emotions, she felt more connected with you and was able to share her concerns about …"*
- *"I noticed that when you said X …, the patient reacted Y …"*

Help the learner explore feelings, motivations, nonverbal behaviors – and *why* they did or didn't do or say something.

- *"What was it like for you giving bad news?"*
- *"Say more about that."*
- *"Was there anything that made it hard or uncomfortable?"*
- *"When the patient said … you replied …: Do you remember why you said what you did?"*
- *"What do you think the patient is most concerned about?" "What did the patient want?"*

Suggest alternative strategies. Teach why they are useful.

- *"Sometimes the most helpful thing we can do for a patient is to just "be present," listen, and show that we care."*
- *"Here is a suggestion you can try."*

5. **Check for understanding.**
   - *"Why don't you summarize what we've talked about?"*
   - *"Let's review what we've talked about."*

6. **Make a follow-up plan.** What will the learner try or change in subsequent patient encounters?
   - *"What do you plan to try with the next patient?"*
   - *"With the next patient, consider asking at least two questions about their family / home life."*
   - *"You can try X approach and then we can talk about how it went."*

Source: © Elizabeth A. Rider, MSW, MD 2010. Used with permission.

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Learning mindfulness

> "One way of defining the character of clinicians is to examine their moment-to-moment actions during the course of clinical care. These small actions, cumulatively, describe the clinician as a practitioner and moral agent."
>
> —Ronald Epstein, MD[99]

Teaching professionalism involves encouraging mindfulness in practice. Epstein[99] identifies habits of mind, including presence, self-awareness, attentiveness, and curiosity as key features of the mature professional and notes that the foundation of professional excellence is knowledge of and respect for the patient as a person with needs and values. Micro-ethical competence, as he calls it, requires three factors: self-awareness, interpersonal skills, and the intention of healing.[100] Epstein notes that self-awareness and interpersonal skills can be taught but that intention of healing must be identified during the medical school admissions process and then nurtured and maintained.

Epstein recommends that clinical teachers cultivate mindfulness in learners in two ways: by asking them to observe their own thoughts and feelings when with a patient, and by using reflective questions to help learners discover their own answers.

Figure 6.7 provides examples of Epstein's reflective questions.[99]

Figure 6.7 **Habits of Self-Questioning: Reflective Questions**

- How might my previous experience affect my actions with this patient?
- What am I assuming about this patient that might not be true?
- What surprised me about this patient? How did I respond?
- What interfered with my ability to observe, be attentive, or be respectful with this patient?
- How could I be more present with and available to this patient?
- Were there any points at which I wanted to end the visit prematurely?
- If there were relevant data that I ignored, what might they be?
- What would a trusted peer say about the way I managed this situation?
- Were there any points at which I felt judgmental about the patient—in a positive or negative way?

Source: Borrell-Carrio F, Epstein RM. Preventing errors in clinical practice: a call for self awareness. Annals of Family Medicine 2004; 4(2): 310–316. Reprinted with permission.

Narrative medicine and storytelling

> "Culture consists of the matrix of stories, symbols, beliefs, attitudes, and patterns of behavior in which we find ourselves."
>
> —Jack Coulehan, MD, MPH[68]

Charon[101] describes narrative competence as "the ability to acknowledge, absorb, interpret, and act on the stories and plights of others." Narrative competence develops from the learner's life experience, reflective practice, and positive role modeling.

Reflective writing, where learners reflect on their clinical and other experiences, is one method for increasing learners' awareness of their developing professional identities. Journaling (i.e., asking learners to keep a learning journal) allows learners to recognize their own personal journeys through medicine and helps them to connect what they learn to everyday practice.[102] Structured reflective writing with individualized faculty feedback can enhance teaching about reflective practice.[103]

Frankel states that the best way to teach professionalism is through storytelling.[104] Professionalism is embodied in the stories people tell about their day-to-day experience in medical settings, and stories illuminate the intersection of the formal and hidden curricula.[104] At the Indiana University School of Medicine, students write narratives about their professional experiences at intervals throughout their medical school experience, allowing students and faculty to track their professionalism developmentally.

Quaintance and colleagues[79] at the University of Missouri–Kansas City School of Medicine use an appreciative inquiry approach where students interview faculty members about their professionalism experiences, followed by reflecting on and writing about their teachers' stories. The authors found that this technique of storytelling seemed to deepen students' appreciation and understanding of professionalism.

As noted in Chapter 1, Reis and colleagues[105] recently developed a framework and guide, called the "Brown Educational Guide to Analysis of Narrative" (BEGAN), for crafting faculty feedback on medical students' reflective writing. Educators have also integrated the arts with medical education to enhance communication skills and self-reflection.[106, 107, 108]

Learning in reflection groups

How do we provide environments that promote reflection and the moral development of learners and faculty, both of which are essential for professionalism? Branch[57] proposes several educational interventions, including critical reflection by small groups of students and faculty, faculty role modeling and feedback, and faculty development. Critical reflection groups meet on a regular basis and provide a safe environment where learners can comfortably discuss values and reflect on ethical dilemmas and concerns. Faculty members with reputations for being good role models lead the groups.

The Healer's Art course,[109] a 15-hour elective course offered in 60 medical schools, helps students personally explore issues of meaning, shared core values, and professionalism in medicine. At the end of the course,

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students may write a personal mission statement about their highest professional values, giving them an opportunity to reflect on their concepts of professionalism.[110] The course includes a small group discussion during which learners can share personal experiences, critical incidents, and reflections. Evaluations have shown that the course validates and legitimizes the humanistic components of professionalism and creates a safe community for reflection and discussion.[58]

Professional boundaries

The establishment and maintenance of professional boundaries is an important aspect of professionalism that is not often explicitly taught.[111, 112, 113] Negotiating professional boundaries is a central developmental challenge for all physicians, especially for young trainees as they learn to become professionals.

Common boundary challenges encountered in clinical practice include self-disclosure, gift giving, personal questions, social invitations, and errands or other requests by supervisors.[113] Lapid and colleagues[114] studied psychiatry residents in six programs and found they perceived a need for more education on many topics relating to boundaries and relationships, including requests to work with inadequate supervision, mistreatment of medical students and residents, adequately caring for patients while adhering to work hour guidelines, sexual/romantic relationships between residents and medical students, resolving conflicts between attending physicians and trainees, responding to impaired colleagues, and writing prescriptions for friends and family members.

Gaufberg and colleagues[115] examined the perspectives of third-year medical students in negotiating several boundary challenges. They concluded that students' negotiation of professional boundaries was influenced by the HC and power differences, and recommended increasing awareness of these influences.

Gaufberg developed an interactive teaching session on professional boundaries for medical students and residents. The session uses trigger tape scenarios of common boundary challenges that help learners recognize professional boundary situations, explore boundary issues, and discuss and role-play problem-solving and communication strategies for managing boundary violations. A main theme is teaching the learner to ask: "What is in the best interests of the patient?"[113]

Davidson[116] designed a flexible course module to increase learners' self-awareness, motivation, and professional judgment abilities related to their professional boundaries. Objectives for learners include the ability to:

- Identify boundary violations and understand their impact
- Apply critical thinking skills to complex professional relationship situations
- Increase awareness of self and others, including personal boundary vulnerabilities
- Learn risk-minimizing strategies

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Although developed for licensed social work professionals, the teaching concepts and strategies are relevant for enhancing the professionalism of residents, medical students, faculty, and other learners.

Comprehensive models for teaching professionalism

Some institutions have developed comprehensive and innovative models for teaching professionalism. The following section outlines two models.

Indiana University School of Medicine

The Indiana University School of Medicine (IUSM) implemented a new curriculum based on nine competencies, which include:

- Effective communication
- Basic clinical skills
- Using science to guide diagnosis, management, therapeutics, and prevention
- Lifelong learning
- Self-awareness, self-care, and personal growth
- The social and community contexts of healthcare
- Moral reasoning and ethical judgment
- Problem-solving
- Professionalism and role recognition[66]

All basic science and clinical courses address competencies related to professionalism. In conjunction with this new formal curriculum, IUSM has engaged in a multiyear culture change project to bring the formal and informal curricula into better alignment. The objective is to develop an organizational culture that reinforces the values of the new formal curriculum.

A central tenant of the IUSM organizational change strategy is to foster respectful relationships and partnership in all arenas of clinical care and the medical school environment. A new complexity theory, Complex Responsive Processes of Relating (CRPR),[117] guided this project. CRPR suggests that the patterns of relating that constitute an organization's culture must be continually reenacted. At any moment, anyone can enact different patterns. These small, local disturbances have the potential to amplify and spread, resulting in large-scale organizational change.

The IUSM organizational change project uses appreciative storytelling and reflection on action to promote greater mindfulness of exhibited values and to foster the widespread practice of reflecting on and discussing interactions as they occur. IUSM uses narrative extensively throughout the organization to bring attention to and reinforce community values and good work. IUSM faculty, staff members, and administrators are also invited to participate in faculty development programs in order to build personal awareness and relationship-centered capacity.

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McGill University Faculty of Medicine

The undergraduate medical curriculum at McGill has three central themes: physicianship, the clinical method, and basic sciences and scientific knowledge.[41] Physicianship refers to the two simultaneous roles of the physician: healer and professional. The clinical method is the mechanism through which physicianship is enacted, and includes how the physician relates to patients and what he or she does in the context of patient care.

McGill has instituted integrated courses on physicianship that run longitudinally across all four years of medical school.[118] Educators introduce the roles of healer and professional on the first day of medical school and reinforce them throughout the curriculum. Additional elements of the curriculum include the social contract, communication skills, observation skills and listening, the healer role, and narrative writing about an example of professional or unprofessional behavior the student has observed. During the fourth year, students complete an eight-hour seminar series called “Professionalism, Medicine’s Social Contract, and You.”

McGill also established a mentorship program. Recognized mentors receive salary support and work with a group of six students throughout medical school. The mentors also supervise student portfolios on physicianship.

The graduate training program at McGill uses a similar approach. All residents in all specialties participate in a variety of activities that address components of professionalism. Second-year residents attend an annual half-day workshop, “Professionalism for Residents.” Residents also participate in cross-specialty and department-specific learning activities including small group discussion, grand rounds, lectures, retreats, and workshops.[119]

Snell[119] outlines the essential elements for teaching and learning professionalism at the resident level. These are taught through a variety of methods at McGill, and include learning the cognitive base and skills of professionalism, developing professional attitudes and fostering professional behaviors, evaluating professionalism, and faculty development.[119] McGill has instituted a comprehensive program of faculty development in professionalism,[120] described later in this chapter.

Assessment of Professionalism

> “Professionalism must remain a topic and focus for debate and discussion. The surest enemy of professionalism is the assertion that we have developed the necessary measurement tools and learning environments—and thus we can call a halt to the arguments, debates, and discussions.”
>
> —Fred Hafferty, PhD[23]

The ACGME and other organizational requirements for competence in professionalism provide an impetus for training programs to teach and evaluate this competency in a more consistent and comprehensive manner throughout medical education. However, the evaluation of professionalism is complex and challenging. No consensus exists as to what to measure or how.

Arnold[121] reviewed the professionalism literature from the past 30 years to examine the state of the art of assessing professionalism. She found that although a

wide array of assessment tools exist, their measurement properties need improvement. Veloski and colleagues[122] concur, noting that there are few well-documented studies of instruments that evaluate professionalism.

Wilkinson and colleagues[123] completed a review of assessment tools for professionalism in an attempt to match given tools to defined attributes of professionalism. They concluded that assessment of professionalism can occur with the use of multisource feedback, observed clinical encounters, patient opinions, simulations, and other methods. The authors found, however, that further development of measures is needed to assess important aspects of professionalism, including reflection/personal awareness, lifelong learning, advocacy, managing uncertainty, responding to audit results, and balancing one's availability to others with caring for oneself.[123]

Part of the difficulty in determining how to evaluate professionalism is that it is a complex construct, not a set of skills, behaviors, attitudes, or steps. Hafferty[30] recommends we keep three questions in mind:

1. How do we effectively define and assess something that is transmitted in a variety of learning environments through a wide range of both formal and informal, even tacit, educational practices?

2. How do we effectively assess something that may be conceived as both practice and identity?

3. How do we design a system of evaluation that assesses both the learners and their learning environments?[30]

How do we assess the physician's competence in professionalism?

"Ensuring that students of medicine at all levels not only acquire but consistently demonstrate the attributes of medical professionalism is arguably the most important task facing medical educators here at the beginning of the twenty-first century."

—Jordan Cohen, MD[143]

Assessment should include both formative and summative evaluations. Formative evaluations assess learning needs, create learning opportunities, guide feedback and coaching, promote reflection, and shape values.[125] Summative evaluations generally judge competence in high-stakes evaluations for promotion, licensing, and certification, and thus require a high degree of psychometric reliability and validity. Evaluation serves various purposes, including:

- Rewarding excellent professional behavior
- Identifying learners with deficiencies in professionalism
- Dismissing the occasional learner who is unable to be professional
- Improving patient care
- Raising institutional awareness
- Identifying role models

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- Providing a vocabulary for communicating about professionalism

- Ensuring continuous quality improvement of individuals or the system

Accordingly, methods for evaluating professionalism will vary based on the purpose of the evaluation.

Epstein and Hundert[126] recommend that a strong mentoring system accompany any assessment program. Without a good system for mentoring, feedback, and remediation, any assessment is weakened and possibly even undermined. They also note that a similar process of reflection, feedback, and remediation can occur at the institutional level to guide curricular change.

Lynch, Leach, and Surdyk[127] recommend a relationship-centered framework for identifying curricular content and assessment areas in professionalism. They suggest evaluating aspects of relationships in five levels: patient–physician, society–physician, healthcare system–physician, physician–physician, and physician–self.

Suggested methods for the evaluation of professionalism

> "Unfortunately, professionalism remains among the most difficult domains of doctor competence to assess. Although many promising approaches are under evaluation, no single measure or set of measurements has yet proven sufficiently reliable and valid to meet demanding psychometric criteria."
>
> —Jordan Cohen, MD[26]

The most effective approach to evaluating professionalism is a program of longitudinal assessments that includes multiple assessment approaches; observations by faculty members, team members, peers, and patients; feedback with reflection; and mentoring. Methods of evaluation considered most desirable by the ACGME[128] for the professionalism competency include 360-degree evaluations, objective structured clinical examinations (OSCEs), and patient surveys.[129]

In addition, the ACGME Project Think Tank[130] recommends assessment of ethics knowledge using vignettes with multiple-choice and open-ended responses, as well as assessment of the learning environment through resident questionnaires.

Evaluation approaches to consider in designing a program to assess professionalism include the following:

- Direct observation by faculty, followed by feedback

- 360-degree and multirater evaluations

- Professionalism Mini-Evaluation Exercise (P-MEX)

- OSCE

- Assessment by peers

- Critical incident reports

- Comment cards

- Portfolios maintained by learners and used for self-reflection

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- Use of case vignettes to assess ethics knowledge
- Assessment of the learning environment via resident questionnaires

Direct observation

Direct observation of students followed by constructive feedback from faculty and real or simulated patients is a powerful assessment tool, but a lack of faculty and simulated patient time and training in giving effective feedback can hamper these efforts. Rider and colleagues[131] designed a model program for a related competency, interpersonal and communication skills, with the goal of providing one-on-one observation and feedback for learners while conserving faculty time. Shrank and colleagues assert:

> *As the field of evaluating professionalism matures, there is little question that more direct observation and a more concerted effort toward honest assessment and feedback will move our profession closer to the ultimate goal of reliably evaluating students' professional qualities.*[132]

360-degree evaluations

The use of 360-degree and multirater evaluations provides learners with multiple sources of feedback in the clinical setting. Evaluators may include patients, faculty, multidisciplinary team members, peers, and others. Kirk underscores the importance of 360-degree evaluations for assessing professionalism: "Attending physicians may feel comfortable judging a learner's knowledge and clinical decision-making ability, but they may not know how that person behaves in the middle of the night."[96] However, other authors[133] caution about negative influences that may affect the quality of 360-degree assessments, including situational factors (e.g., amount of time spent with learners), characteristics of the rater (e.g., level of training, lack of interest), and factors relating to the specific assessment criteria. A large number of evaluations are necessary to provide a reliable measure of performance. Chapter 1 includes a unique use of 360-degree and multirater evaluations with gap analysis methodology, developed to promote learner self-insight and enhanced feedback from faculty.[134]

P-MEX

The Professionalism Mini-Evaluation Exercise (P-MEX),[135] developed at McGill University Faculty of Medicine and the University of Toronto Faculty of Medicine, is used for formative evaluation of professionalism in the clinical setting. The P-MEX uses the Mini-Clinical Examination Exercise (Mini-CEX) format, and is useful for promoting self-reflection and awareness of the importance of professionalism in daily encounters, identifying professionalism behaviors, and teaching about professionalism.

OSCEs

OSCEs have been shown to provide reliable and valid assessments of students' humanism, communication, and empathy. Although OSCEs can measure constructs related to professionalism (e.g., humanism, communication skills), these constructs are not professionalism itself. The psychometric reliability of OSCEs for professionalism and ethical behavior is considered too low for use in high-stakes examinations,[26] yet they may be useful for formative evaluation.

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Assessment by peers

Assessment by peers may promote professionalism, teamwork, and communication, and peers may provide insight into a learner's interpersonal skills and professional behavior. Peer assessment also provides learners with the opportunity to gain skills in evaluation and feedback. Leach notes that peer assessment "offers the benefit of professional self-regulation and accountability."[136]

Critical incident reports

Critical incident reports refer to records of individuals' unprofessional behavior. These reports are used to report incidents of unprofessional behavior that are outside of usual norms. van Mook and colleagues[137] recommend that faculty also report minor incidents, without concern that these will lead to dismissal, so that faculty can implement remediation approaches. Repeated instances or patterns of unprofessional behavior identify learners with significant deficits necessitating formal action. Faculty and/or overview groups can consider whether learners are able to accept responsibility for their problems and whether remediation strategies are effective. If critical incidents of unprofessional behavior persist despite remediation attempts, learners may be dismissed.[137]

Comment cards

Various institutions use comment cards or forms to document both positive and constructive comments about the professionalism of learners and faculty. As part of its online Professional Development Portfolio, New York University School of Medicine implemented comment cards. Positive or negative written remarks can be posted to a student's portfolio. The person writing the comments is identified, and the card is automatically sent to the student, the faculty mentor, and the portfolio administrator.[138]

At the University of Maryland School of Medicine, exemplary comment forms and unprofessional behavior document forms are available for use at any time to report on the professionalism of residents, faculty, and students.[139] Comment cards were originally developed for internal medicine residents and subspecialty fellows by the ABIM as part of its Project Professionalism.[140]

Portfolios

Portfolios maintained by learners have attracted increasing interest, and some educators have designed them primarily for professionalism.[138, 141] The ACGME is developing a Web-based learning portfolio for residents to document, organize, and seek feedback on their experiences.[142] The portfolio promotes reflection, both by self-reflection and by sharing reflections chosen by the resident.[80, 143] Although portfolios are not specifically assessment instruments for reflection,[123] significant strengths of portfolios include their connection to reflection and a narrative-based approach to learning professionalism, their promotion of self-directed learning and lifelong learning skills, and their inherent valuing of the individuality and diversity of learners.

Case vignettes

Educators use case vignettes for both teaching and assessment at various levels of medical training. Learners identify the attributes and characteristics of professionalism, and discuss ethical and other aspects of the cases.[144]

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The National Board of Medical Examiners (NBME) is developing an Assessment of Professional Behaviors program to assess behaviors that are essential for safe, effective, and ethical care. Its approach is the assessment of observable behaviors—one component of professionalism—in medical environments using a Web-based system to collect multisource feedback.

The NBME's pilot instrument contains 25 behavioral items, two narrative comment areas (one for praise/commendation and one to record behaviors needing improvement), one global assessment item, and two questions regarding the amount of contact the observer had with the learner.[145] At the time of this writing, the assessment is formative, designed to help learners gain insight into their strengths and their needs for further development regarding their professional behavior.[146]

Please see the last section of this chapter for specific assessment tools and forms for the following evaluation approaches: 360-degree/multirater evaluation, P-MEX, critical incident reports, comment cards, case vignettes, and assessment of the learning environment.

Assessing the professionalism of the learning environment

The learning environment, with its HC and organizational culture, plays a significant role in the development of professionalism in its learners. The LCME recently developed a new accreditation standard that requires ongoing evaluation of the learning environment and the development of strategies to enhance its positive influences and to mitigate its negative influences.[147] Chapters 1 and 7 provide further discussion on this topic.

Quaintance, Arnold, and Thompson[148] developed a unique assessment tool to measure the "professionalism climate" in clinical settings. Their Climate of Professionalism Survey is presented in the last section of this chapter. Please also refer to the C3[149] instrument in Chapter 1, which measures the patient-centeredness of the HC and other aspects of the learning environment.

Assessment of professionalism starts during the admissions process

Assessing professionalism ideally begins with the admissions process to medical school. Wagoner[150] recommends that medical schools consider recruiting competent, humanistic students with the potential for the highest levels of professionalism throughout their lives. Initial work on considering potential in professionalism as part of the admissions process to medical school has begun at IUSM.[104] Residency programs also can choose to use professionalism as an important factor in their recruitment and selection processes. Chapter 1 lists assessment methods for personal and interpersonal attributes used at the time of selection for medical school or residency.

The Importance of Faculty Development

> "We must acknowledge ... that the most important, indeed the only, thing we have to offer our students is ourselves. Everything else they can read in a book."
>
> —Daniel C. Tosteson, MD[151]

Faculty members are often unprepared to teach and evaluate professionalism. They may be unable to articulate the attributes of the physician as a professional,

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and some may serve as ineffective or negative role models. Faculty development programs in professionalism must focus on individual faculty members and on the learning environments and organizational cultures in which learning occurs.

As noted previously in this chapter, Burack and colleagues[60] studied attending physicians' responses to residents' and medical students' problematic behaviors on the wards and found that attending physicians did not respond to problematic behaviors in any observable way, and they let the majority of incidents pass without comment. Bryden and colleagues[152] studied faculty members' experiences teaching and evaluating professionalism and found that faculty members' own lapses in professionalism and their failure to address these in their colleagues created the most significant obstacle to teaching professionalism. The authors note that "… 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."[(p. 9) 152] The ramifications of such findings are considerable. These studies and others underscore the importance of developing strong faculty development programs for professionalism.

The Mayo Clinic created a professionalism covenant for use in all training programs.[153, 154] The covenant requires educators to "… exhibit the highest standard of personal and professional conduct and confidently expect the same from their learners."[154] The Mayo Clinic learner covenant stipulates that educators also will:

- Instill in learners the core value of professionalism that places the needs and welfare of the patient first, above all other considerations
- Mentor learners in integrity and professionalism
- Demonstrate genuine concern for every learner's success
- Respect learners as colleagues
- Provide an environment enriched by scholarship
- Encourage trainees to become lifelong learners[153, 154]

Viggiano and colleagues note that The Mayo Clinic's value-based culture of service, and its ongoing core focus on the primacy of patient welfare, provides its faculty and learners with "… both a moral compass to guide thought, actions, and reflective practice, and a yardstick to measure their success."[154]

Branch[57] recommends instituting large-scale faculty development programs that emphasize moral education, including its theoretical underpinnings and the importance of an approach that integrates compassion and caring into learners' work with patients. These programs include reflective discussion groups for faculty in which their own values and attitudes are explored.

Steinert and colleagues[120, 155] developed a comprehensive faculty development program to support teaching and evaluation of professionalism at the McGill University Faculty of Medicine. Their guiding principles include:

- Development of a common understanding of the definition, characteristics, and behaviors of professionalism

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- Translation of content into practice by teaching and demonstrating professionalism in the clinical setting
- A focus on teaching professionalism
- Facilitation of experiential learning and self-reflection

Think tanks with educational leaders and invitational and facultywide workshops were part of the faculty development implementation at McGill. Faculty development programs were developed on the topics of teaching and evaluating professionalism and on specific learning strategies, including role modeling and reflection. Outcomes of McGill's faculty development initiative have included increased teaching of professionalism to residents and faculty, revitalization of the curriculum to include an emphasis on the physician as both a healer and a professional,[62] a renewed focus on the assessment of professionalism, and similar faculty development programs in other areas.[120]

Faculty involved in medical education must explicitly teach and model the capacities and values we expect physicians to learn; consequently, faculty development is an essential component of any professionalism curriculum. Faculty development should focus on change at both the individual and organizational levels in order to address the HC and the learning environment.

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Take-Home Points: Principles to Consider for the Development of Programs to Teach and Assess Professionalism

1. Institutional support must come from the top:
   - Enlist active involvement and support from the dean, associate deans, department chairs, program and clerkship directors, and multidisciplinary leaders to fortify the message that professionalism is important and valued
   - Initiate programs to enhance professionalism across the institution
   - Request support from institutional leaders including allocation of teaching time, space, and financial resources
2. Select or adapt a definition of professionalism to use as a conceptual framework institution-wide for teaching, evaluation, and setting expectations.
3. Provide formal instruction in the knowledge base of professionalism:
   - Make explicit the idea that professional status is a privilege granted by society and can be changed if society chooses
   - Teach the nature of professionalism, its historical base, attributes, and values, and the social contract between medicine and society
   - Teach learners the attributes of the two simultaneous roles of the physician, healer and professional, and reinforce these throughout the curriculum
   - Ensure that faculty development programs provide faculty with the same understanding and conceptual framework for professionalism as that taught to learners
4. Design the curriculum to foster self-reflection and the moral development of learners and faculty members:
   - Provide developmentally appropriate experiences and the opportunity to reflect on those experiences.
   - Include structured opportunities, including one-on-one mentoring and small group learning, for learners to discuss professional issues in a safe environment.
   - Design learning opportunities to enhance moral reasoning, awareness of ethical issues, and appropriate moral actions
   - Use varied teaching methods to develop reflective capacity in learners and faculty. Implement:

Take-Home Points: Principles to Consider for the Development of Programs to Teach and Assess Professionalism (cont.)

    - Attention to role modeling with reflection
    - Reflective feedback as a strategy for facilitating and enhancing reflection
    - Teaching of mindfulness
    - The use of reflective writing, narratives, and storytelling
  - Use critical reflection groups for learners with:
    - Regular small group meetings where learners can become comfortable discussing values, attitudes, feelings, and beliefs
    - Provision of a "safe" group environment whereby learners are free to reflect and to honestly share ethical dilemmas and issues
    - Faculty members who are positive role models to lead the groups

5. Create an education program in professionalism that spans the undergraduate and graduate curricula and residency programs across the institution:
   - Such a program should be longitudinal and ensure repeated opportunities to learn and reflect on professionalism
   - Implement varied educational approaches: Create teaching strategies to enhance reflection (noted earlier); utilize small group learning, seminar series, retreats, workshops, grand round presentations, and free-standing required courses; add professionalism-related content (ethics, moral reasoning, self-reflection, professional boundaries ,etc.) to new and existing courses; provide one-on-one mentoring and supervision; require involvement in community service and patient advocacy experiences; and others
6. Explicitly address the hidden curriculum and create ethical learning environments
   - Articulate, teach, and expect good values, demonstration of respect for patients and colleagues, and attitudes and behavior consistent with professionalism
   - Utilize discussion, writing narratives on professionalism, storytelling, and reflection to make the hidden curriculum explicit and to foster the development of professionalism
7. Identify teachers who can serve as good role models and who can create and maintain learning environments built on relationship, safety, trust, and respect:

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Take-Home Points: Principles to Consider for the Development of Programs to Teach and Assess Professionalism (cont.)

- Understand the critical role of the learner–teacher relationship in the development and nurturing of professionalism in the learner
- Ensure that faculty know that the learner–teacher relationship sets the stage for the physician–patient relationship and for professional identity and behavior
- Remove poor role models from teaching roles; they are harmful to the development of professionalism and are associated with cynicism in learners

8. Provide formative and summative assessments of professionalism:

- Use multiple longitudinal evaluations with frequent observation and feedback, multiple assessment methods, and multiple observers/raters including faculty, team memebers, patients, and families
- Develop a mechanism for recording critical incidents and lapses in professionalism, and protocols for remediation and dismissal where necessary
- Provide positive feedback about good professional attitudes and behaviors to reinforce these and increase the likelihood that they will endure
- Evaluate professionalism during the admissions/selection process for medical school, residency, and fellowship programs

9. Faculty development is key:

- Develop a core group of teachers able to facilitate the teaching and learning of professionalism; involve as many faculty members as possible from all levels and specialties
- Teach faculty how to give feedback and teach reflection
- Increase faculty and resident awareness of their influence as role models 24/7
- Provide faculty with reflective discussion groups of their own as an arena for clarification of values and attitudes, self-reflection, and peer support for dealing with students and residents presenting poor professional attitudes or behavior

10. Appoint a designated professionalism curriculum director or group to ensure that teaching and assessing this competency is included where relevant and appropriate. Integrating professionalism into the ongoing training curriculum requires long-range planning and intent.

Adapted in part from 26, 57, 69, 98, 118.

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Conclusion

> "What we have before us are some breathtaking opportunities disguised as insoluble problems."
> —John W. Gardner, 1965 speech

Physicians must be professionally competent and capable in order to effectively practice medicine. Traditional medical education focuses on enhancing competence—knowledge, skills, and attitudes. Fraser and Greenhalgh[156] encourage educators to enable not just competence, but also capability—the extent to which individuals can adapt to change, generate new knowledge, and continue to improve performance.

Significant work remains. Medical institutions and organizations must act decisively to put the public interest—the welfare of our patients—first. The greatest challenge will be to create change to reinforce the values of professionalism in the organizational cultures and learning environments of our medical institutions. We must address the hidden curriculum, create ethical learning environments, attend to the moral and ethical development of our learners and faculty, develop self-reflective ability in our physicians, and pay constant attention to our role modeling. Faculty development remains essential.

Cohen states, "The physician professional is defined not only by what he or she must know and do, but most importantly by a profound sense of what the physician must be. Character, integrity, honor, moral fiber—these attributes are essential."[157] We can accomplish no less. Society, our patients, and our profession have much to gain.

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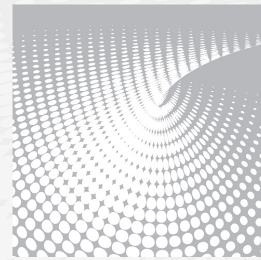
APPENDIX

Innovative Approaches, Models, and Assessment Tools for Teaching and Assessing Professionalism



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States that tax products and shipping and handling: CA, CO, CT, FL, GA, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, NC, NJ, NM, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV.

State that taxes products only: AZ.

BILLING OPTIONS:

☐ Bill me ☐ Check enclosed (payable to HCPro, Inc.) ☐ Bill my facility with PO # ____________

☐ Bill my (✓ one): ☐ VISA ☐ MasterCard ☐ AmEx ☐ Discover

Signature Account No. Exp. Date

(Required for authorization) (Your credit card bill will reflect a charge from HCPro, Inc.)

Order online at *www.hcmarketplace.com*

Or if you prefer:

MAIL THE COMPLETED ORDER FORM TO: HCPro, Inc. P.O. Box 1168, Marblehead, MA 01945

CALL OUR CUSTOMER SERVICE DEPARTMENT AT: 800/650-6787

FAX THE COMPLETED ORDER FORM TO: 800/639-8511

E-MAIL: *customerservice@hcpro.com*

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