Professionalism in medicine: definitions and considerations for teaching

Lynne M. Kirk, MD

> Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.
>
> —Epstein and Hundert (1)

Physicians and medical educators are expected by a multitude of constituencies to consistently demonstrate professional behavior. Epstein and Hundert's definition of professionalism is a very useful one. This definition is an entry to considering what professionalism is and demonstrates the lofty goals of professionalism. In this article, I review other definitions of professionalism, consider specific behaviors that demonstrate the values of professionalism, and focus on aspects of teaching professionalism to medical students and residents.

At the root of professionalism is our profession. A profession requires acquisition and application of a body of knowledge and technical skills. The individuals in a profession are bound together by a shared commitment. Members of a profession regulate themselves. In medicine, physicians regulate themselves through state medical boards, as well as hospital committees and other peer-review groups. Those in a profession practice in accord with a code of ethics. Finally, a profession has a contract with society.

Our profession is to heal. In a patient encounter, we consider a right and good healing action for that patient in his or her particular circumstances. A *right* healing action is one informed by the scientific and clinical evidence. A *good* action, in contrast, takes into account the patient's values and preferences and is consistent with the physician's own clinical judgment. Clinical judgment consists of three steps, then: 1) the diagnostic question—What is wrong with this patient?—taking into account the patient's medical history, physical examination, laboratory test results, and other data; 2) the therapeutic question—What can be done for this patient?—which is frequently informed by the scientific evidence and which comprises the array of treatments that might help the patient; and 3) the prudential question—What should be done for this patient?—which clearly needs to involve the patient to determine the option that will work best.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) implemented general competencies, applicable to every specialty, that need to be imparted during residency or fellowship training. One of these six competencies is professionalism *(Table 1)* (2).

Table 1. The professionalism requirements of the Accreditation Council for Graduate Medical Education*

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

*From reference 2.

The same year that professionalism was listed as an ACGME general competency, the Medical Professionalism Project was launched by the American Board of Internal Medicine Foundation, the American College of Physicians Foundation, and the European Federation of Internal Medicine. The result was a professionalism charter, which was published in 2002 (3) and has subsequently been adopted by many major professional physician organizations.

The professionalism charter defined three fundamental principles of professionalism:

- The primacy of patient welfare: This principle focuses on altruism, trust, and patient interest. The charter states: "Mar-

From the Division of General Internal Medicine, Department of Internal Medicine, The University of Texas Southwestern Medical Center, Dallas, Texas.

Presented as the Lloyd Wade Kitchens Memorial Lectureship, internal medicine grand rounds, Baylor University Medical Center, August 15, 2006.

Corresponding author: Lynne M. Kirk, MD, Hartman Professor of Medicine, Associate Dean for Graduate Medical Education, and Associate Chief, Division of General Internal Medicine, The University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas, Texas 75390 (e-mail: Lynne.Kirk@UTSouthwestern.edu).

ket forces, societal pressures, and administrative exigencies must not compromise this principle" (3).

- Patient autonomy. This principle incorporates honesty with patients and the need to educate and empower patients to make appropriate medical decisions.
- Social justice. This principle addresses physicians' societal contract and distributive justice—that is, considering the available resources and the needs of all patients while taking care of an individual patient.

The charter also listed 10 related professional responsibilities *(Table 2)*.

The social justice principle has been the most controversial element of the charter, when considered by other professional organizations. Physicians can take these important principles and add the depth that's needed to apply them in their own settings.

Table 2. Professional responsibilities defined by the charter on professionalism*

- Commitment to professional competence
- Commitment to honesty with patients
- Commitment to patient confidentiality
- Commitment to maintaining appropriate relations with patients
- Commitment to improving quality of care
- Commitment to improving access to care
- Commitment to a just distribution of finite resources
- Commitment to scientific knowledge
- Commitment to maintaining trust by managing conflicts of interest
- Commitment to professional responsibilities

*From reference 3.

OPERATIONALIZING CONCEPTS FOR TEACHING

Challenges

In teaching the concepts of professionalism, several challenges arise. Just presenting students with lists of what is involved in professionalism may be daunting. Students also have negative role models from the media to contend with. In television shows like *Grey's Anatomy, House, M.D.,* and *Scrubs,* the physician characters often model unprofessional behavior. We've started using segments of these shows for discussion, asking students what they thought about a particular scene or what was wrong with it. It is useful for them to be able to recognize unprofessional behaviors in others.

Another challenge described in the medical education literature is the "hidden curriculum." Even while a medical school or institution defines its values, those in it may at times model unprofessional characteristics and thus undermine the educational objectives. Students enter medical school with idealism, with a commitment to being good doctors, taking good care of patients, and being successful in the profession. Yet, they can begin to lose that idealism early on. Using an instrument that examines moral reasoning, researchers have shown that medical students finishing medical school have more cynicism than nursing students finishing nursing school. Thus, experiences during medical school seem to undermine some of the professionalism educators try to impart. Other examples of the effects of the hidden curriculum include students' tendency to detach from patients, more than is needed to maintain professional responsibility; their loss of reflection and a turning to rote actions based on expectations about what a physician in a particular specialty is supposed to do; their acceptance of hierarchy; and their identification with specialty-based modes of being a physician.

A third challenge relates to giving feedback. When teaching medical students, it may not be very helpful to them to use the definition from the opening of the article and say, "You know, you aren't quite up to par on habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection." Neither is it particularly helpful to rate them on professionalism on a scale of 1 to 9 with no further comment. This challenge can be met by using a behavior-based orientation when teaching professionalism.

Moving from values to behaviors

Generally it is difficult to observe and measure values. In addition, the use of value terms in giving feedback to students, residents, and colleagues can be very threatening and imply character defects. Many see values as something they're born with or bring to the profession, something that can't be changed. In contrast, behaviors are observable and measurable. It is less threatening to tell someone that in a particular circumstance he or she lapsed from the correct behavior. It is also easier to explain exactly what should be done and, consequently, easier for the person to remediate.

In the changing focus from values to behaviors, however, sight of the overarching values is not lost. Good feedback explains not only what should be done but why—and that gets back to the value. However, by starting with behaviors, educators have more information and more ability to act on it.

Jim Wagner, MD, associate dean for student affairs at the University of Texas Southwestern Medical School, has divided the knowledge medical students need to learn into cognitive and noncognitive categories. Educators are generally good at evaluating the cognitive skills, such as data gathering, diagnosis, management, ability to perform procedures, and use of information technology. Competency in professionalism, however, tends to involve noncognitive skills, including communication (language, empathy, integrity, compassion), collaboration (responsibility, respect, duty), and continuous improvement (recognition of limitations, motivation to improve). Dr. Wagner has linked some of these noncognitive skills, or values, to specific behaviors *(Table 3)*.

Part of the benefit of focusing on behaviors is the ability to provide more informative feedback. If you tell a student, "You're irresponsible," he or she may argue about that statement. However, if you describe specific behaviors to students, such as, "You forgot to check on Mrs. Jones' lab work, and the results weren't available when we needed to use them to take care of her," they can act on that feedback and in the process better

Table 3. Examples of linking professionalism values to specific behaviors*

Values	Behaviors
Responsibility	• Follows through on tasks • Arrives on time
Maturity	• Accepts blame for failure • Doesn't make inappropriate demands • Is not abusive and critical in times of stress
Communication skills	• Listens well • Is not hostile, derogatory, sarcastic • Is not loud or disruptive
Respect	• Maintains patient confidentiality • Is patient • Is sensitive to physical/emotional needs • Is not biased/discriminatory

*From Jim Wagner, MD, The University of Texas Southwestern Medical School.

learn the value of responsibility. This type of feedback does not imply that the student has a flaw in character; rather, it implies that he or she didn't exhibit the ideal behavior in that instance but is likely to do so next time.

Ways to teach professionalism

Various studies have suggested that several steps are involved in teaching professionalism: setting expectations, performing assessments, remediating inappropriate behaviors, preventing inappropriate behaviors, and implementing a cultural change.

The first step is defining the characteristics of expected behavior for the institution. Policy statements can be developed that detail unacceptable behaviors. It is also important to describe processes: reporting channels, due process, absence of retaliation for those who report behavior, remediation processes, and follow-up. As they enter an institution, students, residents, and staff should receive a list of expected behaviors for which they will be evaluated and held accountable. The consequences of acting inappropriately should be explained. If concerns arise, a process should be established that would be systematically applied and very likely to achieve the appropriate outcome for all involved. Problems with physician professionalism are beginning to be treated like physician impairment issues. If a concern is raised, it will be investigated.

Beyond this initial orientation and the written documentation, teaching and role modeling should be incorporated at all levels, and training should be offered in topics such as conflict management, feedback, supervisory skills, and assessment. These are excellent areas for faculty development.

The second step is assessment. Educators should explicitly incorporate expected behaviors into formative and summative evaluations. A formative evaluation is feedback given to help people improve their performance, before the evaluation that will determine the grade, which is the summative evaluation. If learners have difficulties but improve after formative evaluation, their final evaluation should reflect the performance they've been able to achieve. However, if they do not improve, follow-up is needed. It is generally not appropriate to comment only once about a problem or inappropriate behavior and then give the learner a failing grade. When giving feedback, educators should explain consequences. If they have a student who is consistently late to rounds, they can explain what grade will result if that practice continues and what grade might be possible if the student were to begin showing up early to rounds. Students understand grades very well.

Finally, 360-degree evaluations—evaluations by peers, nurses, patients, and a wide variety of colleagues instead of only direct supervisors—are extremely important, especially when evaluating 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.

The third step, remediation, involves early identification of unacceptable behaviors, followed by a meeting to explain what is acceptable and to develop an explicit remediation plan. The possible consequences for not improving should be outlined; these may include probation and dismissal. For all of our professional settings, similar steps can be followed to improve behaviors. Frequent follow-up is required in all of these cases to check on progress, praise improvements, and discuss ways the individual can continue to improve.

Developing a supportive institutional culture is the final element involved in teaching professionalism. Leaders have a responsibility to set expectations, to explicitly talk about and define professionalism. Formal educational programs are also useful. In addition, many activities outside of our work life can help improve both our attitude and our job performance.

Importance of imparting professionalism

So do efforts to impart professionalism to students have any impact? Some evidence suggests that they do. Maxine Papadakis, MD, from the University of California at San Francisco, and colleagues conducted a case-control study correlating students' performance in medical school with subsequent unprofessional behavior, defined as disciplinary action by a medical board (4). Examining individuals who graduated from three medical schools from 1970 through 1999, they found 235 who had been disciplined by US state medical boards between 1990 and 2003 and selected two controls for each from the same graduating class; one of the controls was in the same specialty as the disciplined physician. They gathered information on grades, standardized test scores, demographic characteristics, and unprofessional behavior coded from all data in the student files (including letters of recommendation, evaluations, and dean's letters). Results showed that students who exhibited unprofessional behavior in medical school were three times more likely than those who did not to undergo disciplinary action. Specifically, the code of "severe irresponsibility" (meaning that a notation of irresponsibility occurred in the transcripts of the students at least three times) had an odds ratio of 8.5, and the code of "diminished capacity for improvement" had an odds ratio of 3.1. Diminished capacity for improvement was defined

as a lack of improvement despite counseling. Apathy or poor initiative also correlated with disciplinary action.

This study confirmed the need to teach professionalism and to identify and remediate unprofessional behavior. It showed that if a student or resident is consistently late or consistently doesn't follow through (examples of irresponsibility), those actions should be taken seriously.

SUMMARY

Professionalism is an important component of medicine's contract with society. Not only do we need to make good decisions for our patients based on the evidence in the literature, but we need to apply those decisions in a way that is professional and ultimately helps our patient. Certain behaviors early in medical education do correlate with unprofessional behavior during a physician's career. We need to be vigilant in looking for those behaviors and let our students and trainees know why we're so concerned about them. Physicians are likely to improve in professionalism with training and experience.

In his farewell address as president of the Association of American Medical Colleges, Jordan Cohen, MD, made this statement: "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" (5). What we must be are professionals, and we have clearly described behaviors that can lead us in that direction.

1. Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA* 2002;287(2):226–235.
2. Accreditation Council for Graduate Medical Education. General competencies. Chicago: ACGME, 1999. Available at http://www.acgme.org/outcome/comp/compFull.asp#5; accessed August 16, 2006.
3. American Board of Internal Medicine Foundation, American College of Physicians–American Society of Internal Medicine Foundation, European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med* 2002;136(3):243–246.
4. Papadakis MA, Teherani A, Banach MA, Knettler TR, Rattner SL, Stern DT, Veloski JJ, Hodgson CS. Disciplinary action by medical boards and prior behavior in medical school. *N Engl J Med* 2005;353(25):2673–2682.
5. Cohen JJ. "The work ahead": AAMC's president address, November 6, 2005. Available at http://www.aamc.org/newsroom/reporter/july06/word.htm; accessed August 28, 2006.