ASSOCIATION OF AMERICAN MEDICAL COLLEGES

A Flag in the Wind: Educating for Professionalism in Medicine

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Shortly after I joined the staff of the Association of American Medical Colleges in mid-1995, Brownie Anderson and I, along with other colleagues at the Association, embarked on a project – the Medical School Objectives Project (MSOP) - designed to build a consensus on the knowledge, skills, and attitudes that medical students should possess prior to graduating from medical school. It seemed clear to us as we began the project that the knowledge, skills, and attitudes that students should be expected to acquire should be derived from an understanding of the attributes that practicing physicians should possess to meet their professional responsibilities. To gain insight into what those attributes should be, we interviewed a number of distinguished physicians who had written about the challenges of contemporary medicine from different perspectives. Largely as a result of those very insightful interviews, we concluded that physicians needed to posses four major attributes – they should be altruistic, knowledgeable, skillful, and dutiful. Based on that construct, we formulated a set of learning objectives for the medical student education program – learning objectives that defined for practical purposes the role the medical school should play in ensuring that aspiring physicians ultimately achieved the attributes that practicing physicians should possess.

In the process of formulating those learning objectives, we learned that there was very little information available to guide our thinking about the role that medical schools should play in developing in their students an understanding of the meaning of medical professionalism (reflected in the attributes altruistic and dutiful), and how that understanding should guide their behaviors throughout their professional careers. Accordingly, in 1998 we invited a group of scholars who had written about the meaning of professionalism in modern society to participate in a colloquium on the topic. Our hope was that what we would learn from them would guide us in developing an initiative designed to enhance our understanding of how professionalism might be embedded in medical education.

The colloquium was quite successful. Based on the discussions that occurred during the event, a number of the Association's Groups and Councils embarked on professionalism-related activities. By the middle of 2001, we believed that the time had come to try to translate all that had been learned from those activities into a coherent set of recommendations that could guide medical educators in their efforts to accomplish the stated goal within their institutions. While contemplating how we might go about accomplishing this, I learned that Tom Inui had decided to make a professional move, but had not yet determined what his next position would be. Knowing of his longstanding and deep interest in the general topic of professionalism, I tracked him down at the Association's annual meeting to see if he might be willing to spend some time focusing on this issue as a Petersdorf Scholar-in-Residence at the Association. Within a few short weeks, we had agreed on the scope of the activities he would undertake and when he would join us. The rest, as they say, is history.

This masterful report is in every sense Tom's report. Our role was simply to make available to him the resources he needed to be able to devote his time and energy to the project. In the report, he sum-

marizes all that he learned during the time he spent with us. He also presents an exceptional, scholarly analysis of the topic – an analysis derived not simply from what he learned during his time with us, but one very much informed by his own professional life experiences. Finally, he sets forth recommendations that deserve careful reading by academic medicine's leadership. I believe strongly that if Tom's insightful recommendations are adopted and acted upon by the leaders of academic medicine's institutions, we will be well on our way to embedding professionalism in medical education. There is no way to overestimate the importance of accomplishing this for the future of the medical profession, and for the good of the general public and those who will seek care from physicians in the future. The academic medicine community owes a great deal to Tom for undertaking the project and for the extraordinary product he has produced.

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"All professions are conspiracies against the laity."

George Bernard Shaw [The Doctor's Dilemma]

"People of the same trade seldom meet together, even for merriment and diversion, but that the conversation ends in a conspiracy against the public, or in some contrivance to raise prices."

Adam Smith [Wealth of Nations]

"On the contrary, when people of any trade meet together they are far more likely to talk shop than conspire to improve their economic situation. They are more likely to tell war stories, gossip about colleagues, compare working conditions, and trade new information, theories, and tricks of the trade. Doing the same work creates common intellectual and social as well as economic interests."

Eliot Freidson [Professionalism: The Third Logic]

In the first six months of 2002, it was my good fortune and privilege to serve as a part-time scholar-in-residence at the Association of American Medical Colleges (AAMC), focusing my energies on a set of activities intended to bring the domain of 'professionalism' into sharper focus for the staff and constituencies of the Association. To this end, I read broadly in the subject area, emphasizing the literature of the last 10-12 years, and interviewed the staff of the Association who had a special interest in this subject. I knew the topic would be a compelling one for me. It was possible to view my career as a medical educator as one sustained effort to incorporate new teaching and learning content into the core curricula of medical schools that various constituencies (including faculty, students, and residents) thought were essential but underdeveloped domains of preparation for the profession. These subjects included such topics as disease prevention/health promotion, physicians' roles in society, physician participation in improving the quality of health care, population- and community-based determinants of health, and interpersonal relationships in health care (clinician-patient, clinician-clinician, clinician-community).[1] I had also participated in work at the AAMC and elsewhere that reconsidered the mission and functions of medical schools and residencies.[2] I felt reasonably well prepared to take responsibility for this 'project on professionalism.'

There were, however, several problematic aspects of the proposed work, and my engagement in it, that I did not fully appreciate at the outset. First, I did not know that the millennial transition would produce a striking bloom of publications on the topic of professionalism in medicine from every quarter – professional associations, scholars in medicine and other fields (social science, philosophy, law)[3]. In retrospect, the incidence of speaking and writing about this subject had been on the increase for some years, but through my routine reading I had been aware of only a modest fraction of this

activity. For this new project, there was a lot to read and no easy way to circumscribe the subject narrowly (the usual technique of an academic who needs to corral an unruly subject matter).

Second, I did not recognize how personally *vested* I would become in the subject matter as the special project progressed. As I read and interviewed, I began to realize that I was engaged in a discourse about what it *means* to be in a profession like medicine today. I cared about the discourse not only because the ideas were intellectually engaging but also because – with some real degree of seriousness – I thought that our profession's place in our society and culture hung in the balance at present. The seriousness with which we in the profession all immersed ourselves in this subject matter could, in some manner, radically condition our present and future possible roles in medical practice organizations, our status in law, our ability to work within trusting relationships, the kind of research that we could conduct, and ultimately the contribution to health we could make. There was no part of what I cared about in medicine that I could see as independent from this reconsideration of our professional values and attributes. In a clear-cut violation of the "rules" of scholarly inquiry, there seemed to be no 'place to stand' that would permit a depersonalized, disinterested exploration of the subject matter.

Finally, while still in the midst of my reading and interviews with key informants, the general outlines of my 'findings' became recognizable. I do not mean to say that my mind was closed to new thoughts. In fact, I gave myself full license to read quite widely – not only the well-formed opinion pieces that make their appearance in peer-reviewed publications, but also ethnographic accounts of teaching and learning in medicine, survey research on various elements of professionalism among trainees, and raw data from professional meetings and trainee focus groups intended to open new 'windows' on the topic. And, as those whom I interviewed would acknowledge, I worked assiduously to center the inquiry on their ideas, not mine. Nevertheless, the broad stokes of what would become core observations became visible relatively early. They were:

1. The major elements of what most of us in medicine mean by 'professionalism' have been described well, not once but many times.

2. Among these descriptions, there is a high degree of congruence, probably because our general understanding of the attributes of a *virtuous person* serves as a foundation for our thinking about the needed qualities of the trustworthy medical professional.

3. What the literature and rhetoric of medicine lacks is a clear recognition of the *gap* between these widely recognized manifestations of virtue in action and *what we actually do* in the circumstances in which we live our lives.

4. We may be unconscious of some of this gap, but even when conscious we are silent or inarticulate about the dissonance and, in our silence, do not assist our students to understand our challenges when attempting to live up to our profession's ideals.

5. In the process of becoming medical professionals themselves, our students learn powerfully from the systems in which we work and what they see us do (the 'hidden' and 'informal' curriculum), not only from what they hear us say (the formal curriculum).

6. 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.'

7. 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 our selves.

8. The opportunities for change that will enhance the modeling of medical professionalism are myriad, but the most difficult challenge of all may be the need to understand – and to be explicitly mindful of, and articulate about – medical education as a special form of personal and professional *formation* that is rooted in the daily activities of individuals and groups in academic medical communities.

Knowing about the general directions of my conclusions early did not make the crafting of a report easy. If I were going to convince anyone, especially mature academics, to see their daily activities with fresh eyes, this was unlikely to be accomplished by presenting a standard report that repeated content they had seen elsewhere on the 'hidden curriculum.' To compound this difficulty, structuralists and ethnographers would predict that the very behaviors that our students, with their 'fresh eyes,' find striking and use to form their emerging constructs of what it means to be a professional in medicine, would have long since become invisible to the faculty, who have engaged in these behaviors repeatedly. I once asked a senior clinician mentor of mine why he stood outside his patients' rooms before entering, holding the patient's chart in his hands but not actively reading it. "What are you doing?" I asked. "Nothing really" he said, probably alluding to his processes of 'medical reasoning' but ignoring the centering and settling that readied him to be with the patient. Knowing what I would need to say in this report about the 'hidden curriculum', I also knew that I was going to need to focus attention on exactly these kinds of ("nothing really") processes. This specific focus would be necessary because it is in just such situations that, with prepared minds, we might more fully understand our actions (good or bad), recover our language, and be able to teach in ways that express our values, our opportunities, and our special responsibilities in medicine.

For all these reasons, this report takes a hybrid form. There are expository sections, but there are also stories from education and training. The latter are my own accounts, the teaching/learning stories I know best. They are the critical incidents that in some substantive way shaped whom I became in medicine. We all have such narratives. I present them without 'morals', because they can – and I suspect will – be read in different ways by different people. Each precedes a section to which I believe it has some relevance. Uncovering this relevance can be seen as an exercise in understanding the hidden and informal curriculum, but this is not a required assignment. This report can be read in three ways – through the expository text alone, through the stories, or (as it was constructed) in the juxtaposition of both. I hope that a thoughtful reading of the two elements together will produce a deeper understanding of the issues they express than either alone or a simple sum of the parts.

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Medical Professionalism at the Millennium

Hearing the unexpected

My recollections of the interview day at Johns Hopkins are vivid, if incomplete. Like other applicants, I had 'dressed for success' in my best collegiate slacks and jacket and submitted what I hoped would be an interesting record of achievement as a liberal arts undergraduate with a major in philosophy. In preparation for the interviews, I had polished my essay, which expressed the hope that I could be of service to others by entering a helping profession. The interviews seemed to be going well when the flow of the day was put on hold for lunch with a faculty member in the dining room that was then located in one of the great halls of the Welch Library. The occasion had been described as a 'free conversation', not one of the interviews that would be weighed in the balance by the admissions committee. My luncheon host was a neuropathologist in a long white coat. We sat at a small table with Sargeant's portrait of the founding Hopkins faculty presiding over the room from high on the wall behind. "Well, Mr. Inui," he said, leaning back just a bit in his chair and crossing his arms, "What makes you think that you're *tough* enough to go into medicine?"

The profession of medicine can be viewed from several different perspectives, each rooted in different periods of history but all applicable today.[4] From a cultural perspective, physicians (practitioners with scientific roots in biomedicine) are the dominant ***healers*** of our day in North America. Some of their specific functions (attending births and deaths and responding to illness, for example) are old responsibilities that have long been important activities of healers. Many of our 'privileges' – seeing and touching the bodies of others in intimate ways, being trusted with information that in the hands of others might be dangerous – flow first from our place in the culture, rather than from the credibility or utility of our science. We are also a ***guild*** – in classical terms a skilled trade with restricted entry largely mediated by successful completion of a term of apprenticeship. This characterization of medicine in North America is not new. It was an accurate description of allopathy from our earliest days as a nation and has not lost currency as the number and diversity of medical schools was substantially reduced after the Flexner report, national examination for state licensure emerged, and post-graduate training with board certification became the norm. At special times in the last century, medicine has also been treated as a ***social good***, a service utility, and practitioners of medicine as civil servants. While we as a nation have never established a national health insurance or a national health service, in times of special need (war, global depression) and when physician scarcity was thought to be a problem, we have drafted physicians, used public funds to support their education and training, and even organized physician health services for special populations (the Indian Health Service for Native Americans and the Farm Security medical cooperatives for agricultural workers, for example).

In the last half century, the term 'medicine' is almost synonymous with 'biomedicine', as reductionistic sciences of biologic, genetics, and cellular biology have hit their stride. With the flourishing of biomedical science and the substantial public investments in medical research through the National Institutes of Health, medicine increasingly has been viewed as a ***scientific and technical domain*** that

is producing important advances in the care of patients with acute and chronic disease. Finally, as employment-based and public programs for insuring the public became common and the goods and services of medical care became more expensive, medicine has become a significant sector of the overall U.S. economy, accounting for about 15% of the gross domestic product nationally. American medicine is an ***economic engine*** without peer today. Physicians are among the most highly compensated workers in our society, hospitals and academic medical centers are major employers in their communities, and some entire cities (Birmingham and Pittsburgh, for example) have essentially converted their economies from an older manufacturing and fabricating industry (iron and steel) to centers of biomedical enterprise.

Given this manifold presence for medicine in our times, it may not be at all surprising that at the turn of the millennium, scholars in diverse disciplines and several professional associations of medicine seem to be focused on the values of medicine, the core competencies of the physician, and the essential attributes of professionals in the field of medicine. Furthermore, no matter what construct of medicine we might chose to consider, all have been thrown into question by recent circumstances. Perceptions of physicians as healers have been complicated by the recognition of medical error and iatrogenic injury and the need to minimize morbidity and mortality caused by medical care.[5] The general public, not just patients with grievances, understands that physicians make mistakes and that every potentially helpful therapy carries a risk of harm. This is certainly not a new issue (witness the Hippocratic Oath's injunction against 'cutting on stone'), but mass communications and an emphasis on litigation as a mechanism for social justice has raised to a greater level of public awareness the harm physicians can do. Acting as a modern-day 'guild', the kind of well-intended but arguably self-regulating or monopolistic mechanisms we have put in place to increase the diversity of student bodies in schools of medicine (affirmative action programs) and assure the match of graduating students seeking desirable residencies with hospital programs seeking desirable residents (the NRMP) have both become targets of legal action in recent times. While the average citizen understands that physicians are a critical resource for the health of the public, and would even express a high level of confidence in the good qualities of his/her own physician, survey data over decades shows that the levels of trust and respect that were extended to the profession of medicine 40 years ago have been substantially eroded.[6] This loss of trust compounds the difficulty we face as a profession working in the economic sector of medicine. Because we are highly compensated and control (or at least highly influence) the majority of decisions in practice that drive resource allocation and expenditures, we can be viewed as self-dealing entrepreneurs who are part of profiteering in health. It can even be problematic to speak as an advocate for universal health insurance today because of the likelihood that we will be seen as self-interested advocates for the very programs that will enrich us further. Finally, while few would see the fruits of biomedical research and technologic innovation in use today as unwanted baggage, many citizens lament the substitution of technology for care with a personal touch and worry about the uses of technology that may not express their wishes or values.

Overall, it is not a comfortable time to contemplate the state of medicine. Given all the social flak being detonated around us, it would seem constructive to turn again to such fundamental questions as: What should we know? Be able to do? Hold dear? It is just these questions that have been the focus for 'professionalism' deliberations in the past three years by various organizations and individuals in medicine, including:

- the AAMC (in the Medical School Objectives Project, for example) and through the activities of several of its constituency sub-organizations (representing students, faculty, and accreditation functions)[7]
- the Accreditation Council for Graduate Medical Education (the ACGME Outcome Project)[8]
- the American College of Physicians/American Society of Internal Medicine with the American Board of Internal Medicine Foundation and the European Federation of Internal Medicine (the Medical Professionalism Project and the Charter on Medical Professionalism)[9,10]
- the British Medical Council (the Good Medical Practice project) and the British Medical Association (Core Values of the Medical Profession in the 21st Century)[11]
- the National Board of Medical Examiners[12]
- clerkship directors and others in the Association of Professors of Medicine[13,14]
- independent scholars writing on the domains of professional competence (Epstein/Hundert), medical professionalism (Swick), medicine as a profession of service (Cruess/Cruess), measurement and evaluation of professional behaviors and values (Arnold), and the curriculum for professionalism in medicine (many), among others.[15,16,17,18,19]
- at least one private foundation (interestingly, one that focuses its support on activities that it considers especially relevant to the evolution of whole societies) has supported a series of dialogues and social action projects focused on "medicine as a profession" (Rothman).[20]

Why are we talking so much about professionalism?

Expanding the notion of 'medical findings'

At my medical school, we were assigned in groups of four to preceptors who oversaw our work as we learned how to interview patients, do physical examinations, and write up our observations. My group's preceptor, then a hospital chief of medicine, later an academic affairs dean, and ultimately a Chancellor, assigned us to a patient in a chronic disease hospital who was – much to our amazement – hemiplegic and aphasic. Sometimes dozing and, at other times, alert and looking piercingly at each of us, she appeared as though she might be trying to say something. We struggled to find a way to communicate meaningfully with this young woman, hoping she could give us yes or no responses to the questions we had memorized as the fundamentals of 'the medical history.' "Grab the white straw if you want to say 'yes' and the blue straw if you want to say 'no' – OK?" Having spent nearly all our available time in this ultimately futile effort to communicate, the four of us finally tried to conduct a cursory physical examination in the few minutes remaining. When our preceptor arrived, he was amazed at how little we had accomplished and - most of all - that we

> hadn't paused to ask ourselves how and why a young woman might have had a stroke. We were all standing at her bedside at the close of our session when we asked him whether he thought she could understand us. He said that he didn't know, but always assumed that a patient, even one who seemed unlikely to understand, could hear and would find meaning in anything we might say. At this instant, the woman reached out with her good hand to touch him. All of us came back later to try to hear the opening sound and the diastolic rumble of her mitral stenosis, as well as to talk.

My own belief is that the present intensity of our discourse about professionalism in medicine represents both a flight from commercialism, on the one hand, and a corresponding need to reaffirm our deeper values and reclaim our authenticity as trusted healers, on the other.[21,22] There can be little doubt that physicians in general as well as the leadership of the organizations of medicine have been preoccupied with finances and the economics of medical care. In my own experience both the topics and the language of academic leadership have shifted in the last twenty years. Deans' offices and faculty councils spent more time on collection rates, reviewing business plans, optimizing return on investment, and getting leverage in the marketplace. Core functions of the academic medical center became 'enterprises' – the research enterprise and the clinical enterprise. Teaching of medical students, because this activity was not remunerative, was referred to as 'an unfunded mandate.' Some of this shift in the discourse represented, from one perspective, a useful appearance of the sort of financial sensibility and accountability that can and should exist in any organization. Some of the shift, however, also represented the affirmation of the legitimacy of an entrepreneurial motivation in medical practice and the importance of the marketplace.

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From many respects, this last decade in U.S. medicine has represented a national experiment with 'putting medicine into the marketplace,' with attendant emphases on transactional relationships ('patients as customers') and the commodification of medical care.[23] Within the profession of medicine, however, not everyone was comfortable with this shift and orientation. While timely and efficient delivery of service on demand might be an optimal response to acute illness in the otherwise healthy patient, individuals with chronic and complex conditions are likely to be best served by longer-term relationships with physicians and teams who can provide the coordination, continuity, and comprehensiveness needed to support their well-being. Providing this kind of care in a marketplace that rewards technical and procedural services and within plans and organizations that emphasize short-term financial returns was fraught with difficulty. As pressures (self-imposed or organizationally mandated) for productivity rose, the question became "Is financial success all-important, or is there some other way to think about what also matters?" It is in this latter context that I think physicians generally, and the leadership of

organized and academic medicine in particular, began to examine their core values, principles, and competencies (technical and interpersonal). Stated in other words, they turned to the question of what it means to be a professional in medicine and, by implication, what it takes to stake a claim to all the privileges acceded by our society to a professional.

Ironically, at the very time that physicians were becoming re-engaged in the exploration of professionalism, the meaning and status of a 'professional' was being actively deconstructed, in medicine and in other sectors.[24] In historical hindsight, while scholars in this domain read the record variably, several usages of 'professionalism' have probably been in parallel play throughout the twentieth century. Early in the twentieth century, for example, a 'professional' simply referred to someone who was paid for his work, in contradistinction to an 'amateur'. Bobby Jones, at one time the world's best golfer, was an amateur sportsman (meaning that he didn't accept money for winning tournaments) but a professional lawyer. Later, Freidson[25] (among others writing before and after him) emphasized that the work sectors we refer to as 'professions' are learned and largely self-regulating. Still later, especially as science and technology advanced post-WWII, 'professional' increasingly denoted highly educated and *specialized* workers, since specialty knowledge (in engineering, mathematics, biology, law, and other fields) was becoming the hallmark of high-status disciplinarians. Finally, at least in the second half of the twentieth century, many other workers staked a claim to use of the term 'professional' as it came to mean, at least in common parlance, simply 'good at what he/she does' (professional cleaners, professional plumbers, professional pitch hitters). Perhaps the *reductio ad absurdum* event is underway in mid-2002, as we debate which workers around the world will be eligible to be listed on the Internet as a '.pro' (professional).[26] Given this highly democratic social appropriation of the construct of professionalism, even if medicine could resoundingly reclaim its status as a profession, what would this mean?

What is 'professionalism'?

Turning myself in

Sometime late in my internship I was running out of patience with certain aspects of my work – particularly with the heroin addicts who accounted for about one-third of the admissions to the ward. In the wee hours of the morning during one admitting day, I was tired but on top of my patients, so I called the ER to see where I was on the rotating list of admissions, only to learn that an 'addict with fever – a rule out endocarditis' case - was about to be sent up to me. About the time I hung up the phone, a snarling man - who was clearly about as happy as I was with his situation - rolled by in a wheel chair. At his bedside, in order to expedite his workup, I made a major mistake and tried to open our relationship by drawing blood cultures. In those days, five or six were needed, all from separate 'sticks,' and his habit had left well-developed tracks but no visible veins. I tried twice and only succeeded in making him intensely angry with me. Sweating, angry myself, and headstrong, I told him I was going to do a femoral stick. "Like hell you are! Damn mother f…er" or some minor variation of this retort was his response, sitting there as the living, breathing embodiment of my failure to do what I was suppose to do. Blind with anger, sick of 'taking care of people

> who are ruining their own health,' and tired beyond description, I turned the syringe in my hand needle down, raised my arm, and stabbed it into… the mattress just beside his leg. Pulling it out, and without further words to him, I went back to the nursing station, called my resident, and turned myself in for unprofessional behavior. I'll bet he loved being paged at 3am for that.

One avenue into a deeper understanding of what we hope to reclaim would be to examine what members of the profession are writing - the discourse from within medicine - about the nature of professionalism. As Freidson has noted[27], it is only with clarity and a common understanding about expected conduct, personal qualities, aims, and values that a worker group can lay claim to special social privileges (like relative professional autonomy and self-regulation), and that society will accede to such claims. However much special knowledge and esoteric technology we have, if we cannot be trusted to share values with our patients and act accordingly, we will not be able to take the risks we impose on our patients and ourselves when doing our work.[28] This assertion is as true of the risk we incur when we blithely tell patients to "Go ahead and get undressed" as we step out of the examining room as it is of doing coronary artery bypass surgery because we think it will help someone live longer. In the end, it is *not* because we have special knowledge and technology that we can be trusted – instead, we are trusted only if this knowledge and technology is firmly attached to values that are explicit, understood, and (when push comes to shove) altruistic. We not only need to be trusted, we need to *deserve* the trust of our patients and the public. What are the essential attributes of the trustworthy physician?

> ***In the end, it is not because we have special knowledge and technology that we can be trusted – instead, we are trusted only if this knowledge and technology is firmly attached to values that are explicit, understood, and (when push comes to shove) altruistic.***

There are multiple good sources for leading suggestions from authoritative sources on this question. Through the lens of the AAMC's Medical School Objectives Project, one would see the attributes of the good physician as falling into four large domains – being knowledgeable, skillful, altruistic, and dutiful (Table 1).[7]

Table 1. Alternative Views of Professionalism in Medicine: AAMC Medical School Objectives

- Knowledgeable (scientific method, biomedicine)
- Skillful (clinical skills, reasoning, condition managing, communication)
- Altruistic (respect, compassion, ethical probity, honesty, avoidance of conflicts of interest)
- Dutiful (population health, advocacy and outreach to improve non-biologic determinants of health, prevention, information management, health systems management)

A similar (high level of abstraction) table from the ACGME Outcome Project has similar content (Table 2).[8]

Table 2. Alternative Views of Professionalism in Medicine: Accreditation Council for GME

- Medical knowledge
- Practice-based learning and improvement
- Patient care
- Systems-based practice
- Interpersonal and communication skills
- Professionalism (respect, compassion, integrity; responsiveness to needs; altruism; accountability; commitment to excellence; sound ethics; sensitivity to culture, age, gender, disabilities

The "Physician Charter" of the ABIM/ACP-ASIM/EFIM emphasizes many of the same values, while framing them in the language of principles and commitments (Table 3).[10]

Table 3. Alternative Views of Professionalism in Medicine: A Physician Charter (ABIM, ACP-ASIM, EFIM)

- Professionalism – a foundation of the social contract for medicine
- Principles: primacy of patient welfare, patient autonomy, social justice
- Commitments:

Professional competence	Scientific knowledge
Professional responsibilities	Managing COIs
Patient confidentiality	Honesty with patients
Improving quality of care	Improving access to care
Appropriate relationships	Just distribution of finite resources

Finally, two compelling statements about what physicians are expected to do (normative behaviors as members of their profession) constitute their own functional description of professionalism in action (Tables 4 and 5).[11,16]

Table 4. Alternative Views of Professionalism in Medicine: A "normative definition" (H. Swick)

Physicians:

- Subordinate their own interests to those of others
- Adhere to high ethical and moral standards
- Respond to societal needs
- Evince core humanistic values (honesty, integrity, caring, compassion, altruism, empathy, respect for others, trustworthiness)
- Exercise accountability
- Demonstrate continuing commitment to excellence
- Exhibit commitment to scholarship
- Deal with complexity and uncertainty
- Reflect on their actions and decisions

Table 5. Alternative Views of Professionalism in Medicine: "The duties of a doctor" (General Medical Council)

- Make the care of your patient your first concern.
- Treat every patient politely and considerately.
- Respect patients' dignity and privacy.
- Listen to patients and respect their views.
- Give patients information in a way they can understand.
- Respect the right of patients to be fully involved in decisions.
- Keep your professional knowledge and skills up-to-date. Recognize the limits of your competence.
- Be honest and trustworthy.
- Respect and protect confidential information.
- Make sure that your personal beliefs do not prejudice your patients' care.
- Act quickly to protect patients from risk (from physicians).
- Avoid abusing your position as a doctor.
- Work with colleagues in the ways that best serve patients' interests.

Finally, yet another, and even more recent taxonomy of domains of professionalism was used in a recent joint meeting of AAMC and NBME representatives and academicians with relevant expertise.[12] The aims of this meeting were to work within the domains to examine the potential for measurement and evaluation. That taxonomy, derived largely from the work of the Group on Educational Affairs

within the AAMC, but acceptable for the purposes of the meeting to all, also included now-familiar content:

- altruism, honor and integrity (e.g., ethical, honest, moral),
- caring and compassion (e.g., sensitivity, tolerance, openness, communication),
- respect (e.g., for patient's dignity and autonomy, for other health professionals and staff, relationship building),
- responsibility (e.g., for self-evaluation, motivation, insight),
- accountability (e.g., dedication, duty, legality, service),
- excellence and scholarship, and
- leadership

From my own perspective, I have no reservations about accepting any, or all of the foregoing articulations of various qualities, attitudes, and activities of the physician as legitimate representations of important attributes for the trustworthy professional. In fact, I find it difficult to choose one list over others, since they each in turn seem to refer largely to the same general set of admirable qualities. While we in medicine might see these as our lists of the desirable attributes of professionalism in the physician, as the father of an Eagle Scout I know that Boy Scout leaders use a very similar list to describe the important qualities of scouts: "A Scout is trustworthy, loyal, helpful, friendly, courteous, kind, obedient, cheerful, thrifty, brave, clean, reverent (respecting everyone's beliefs)."

> ***when we examine the field of medicine as a profession, a field of work in which the workers must be implicitly trustworthy, we end by realizing and asserting that they must pursue their work as a virtuous activity, a moral undertaking***

I make this observation not to descend into parody, but to make a point. These various descriptions are so similar because when we examine the field of medicine as a *profession*, a field of work in which the workers must be implicitly trustworthy, we end by realizing and asserting that they must pursue their work as *a virtuous activity, a moral undertaking*.[29,30,31,32] All explications of professionalism then devolve into descriptions of the general qualities of a virtuous *person,* one who works in the field of medicine, and how such a virtuous person would act. While the processes of coming to these various descriptions of professionalism differ and may have had formative value in their respective organizational domains, in the end and at a deeper level, the final accounts are all the same. The advice to an educator, then might be simple - if you are seriously interested in professionalism in medicine and need an accounting of the major domains of this concept, take a list – any list – and take it seriously. Consider whether and how your students come to understand and embody such attributes while preparing for a career in medicine. Consider - optimally in a dialogue with your students - what responsibilities publicly holding such high ideals confers on physicians in interaction with their trusting patients, in interactions with their peers, for their actions in the organizations of medicine, and for their roles in their communities.

How do students acquire these attributes?

Recognizing duty

It was always my habit to procrastinate, to put off until the last minute the hard work that needed to be done before writing a paper, taking a test, or doing a presentation in a class. There was a method to my madness – as Samuel Johnson once observed: "the prospect of hanging in a fortnight concentrates the mind wonderfully." The difficulty in my case was that my mind often didn't concentrate until sometime the night before the work was due, somewhat limiting my prospects for learning. Through college and well into the first two years of medical school, however, the habit persisted, even in the face of some rather poor grades. In spite of this adverse experience, there was always a psychological rescue available – just imagine how well I might have done if I had actually been better prepared! I remember well when I stopped playing these games. During our second-year pathology course a section discussant took us on our first 'rounds' to see several people who were in the hospital with cancer, in order to help us to understand clinical-pathological correlations. In honesty, I don't remember what diseases these patients had. Instead, I remember how *sick* they were, how feeble, and how they looked deep into my eyes. Feeling the unflinching gaze of a sick patient as he surveyed the little parade of new students of medicine, I felt the need to make some sort of silent promise. It was on that day that the procrastination stopped.

Either because the vast majority of people who apply to medical school have positive personal qualities, or because medical school admissions committees do a credible job in their efforts to identify such applicants, or both, at present selection processes admit to medical school students with many basic positive personal qualities as well as first-rate academic credentials. Many observers of the 'natural history' of altruism, social-mindedness, interest in the psychosocial issues embedded in all illness, and the host of strongly other-directed qualities of the maturing medical student, however, suggest that these attributes *decline* during undergraduate medical education.[33,34,35,36,37] Perversely, even as they mature and assume greater responsibility for the care of patients, medical students' attitudes begin to reflect more self-centeredness and cynicism. In at least one study of cynical attitudes,[34] the last-year medical student displayed measurably greater cynicism that anyone else among the medical personnel of the academic health center – more than younger students, residents, or faculty. What can be happening?

I personally doubt that this is an effect of coursework, the formal curriculum. Nearly all medical schools now have a course or course content in professionalism in medicine, as well as in medical ethics.[38] All schools teach doctor-patient communication, at least the basic skill set for medical interviewing, and many go on to more advanced topics – dealing with the problematic doctor-patient relationship, risk management through better communication, breaking bad news, enhancing therapeutic alliances, assuring adherence through persuasive communication, motivational interviewing, supporting patient and family grieving, understanding and managing conflicts of interest, and still other topics. Many schools have committed at least a portion of the pre-clinical curriculum to small-group learning, an educational method that appears to teach skills for enhanced task sharing and teamwork.[39]

Finally, many schools provide opportunities for students to participate in community service, as a requirement or as an elective activity, recognizing that student projects in support of community health represent their own form of 'problem-based learning' as well as a direct expression of the service ideal.[40,41,42] None of this coursework is apt to deteriorate other-directed (altruistic) student attitudes and create cynicism.

> ***Within the experience of students, but 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. It is this modeling, not only by the faculty but by the residents, that constitutes the most powerful influence on students' understanding of professionalism in medicine.***

Within the experience of students, but 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. It is this modeling, not only by the faculty but by the residents, that constitutes the most powerful influence on students' understanding of professionalism in medicine.[28,32,43,44,45] Whatever we say about the need to conduct thorough informed consent discussions, it is the hurried "Mr. Owens, we need you to sign this form so we can replace your central line" that teaches students how we actually complete this task. All the talk about cultural competency can be undone by offhand comments ridiculing another culture's 'peculiar' ideas. Students hear us lecturing about the importance of supporting positive family dynamics, but they see us choosing to leave the wards before families can arrive to ask questions about their hospitalized relatives. They listen to us lecture about the importance of interdisciplinary teamwork, but they hear harried house staff in internal medicine complain about surgeons, tired surgical house staff complain about internists, and everyone complain about nursing. Even if the latter statement is hyperbole, the fact is that students in their early years take notes in class and imagine that they are getting critically important information, while the same students in their later clinical years watch us to see what really counts. As they rise through the years, it becomes increasingly clear that there are too many facts and skills to actually master, so the question becomes "What do I actually *need* to know to be competent?" [46] It is in arriving at an answer to this question that the hidden curriculum becomes most potent. Further, noting the difference between what we *say* and what we *do*, students learn that medicine *is* a profession in which you say one thing and do another, a profession of cynics.

Can emerging professional attributes be measured?

Measuring and providing feedback

A health services research fellowship that preceded my chief residency in internal medicine served as a foundation for thinking about information systems, the capture of critical information for clinical decision-making, and the use of such systems for improving the quality and efficiency of care. It was not a surprise, then, when I became interested the following year in providing feedback to medicine house staff

on their patterns of laboratory utilization. My impression was that many house staff were wasting resources by engaging in mindless test ordering. Meshing information from the house staff schedules and the clinical laboratory system, I created a database that supported an exploration of lab use by intern, team, and service (floor) for each month, adjusted by the number of admissions, length of stay, and even time of the year. A summary statistic for all lab use was available – lab work units, based on technician time and other resources used in doing the tests. Looking at the data for interns, there was major variation from one to another, even after adjustment, and lab costs were an impressive fraction of the total hospital bill. Feedback took the form of a letter from me to my house staff, with each person's data made visible to them, including contrasts between their level of use and their peers. After several months' time, visible shifts in use started to appear. Nearly everyone's utilization moved towards the mean – all but one of the individuals who had been high-end utilizers ordered fewer labs; all of the low-end utilizers ordered more; those in the middle didn't budge. Overall, I had only made lab use patterns more homogeneous, not more mindful or parsimonious. The difference between providing information and education was never clearer.

Several different approaches to measuring the beliefs and values of students, graduate trainees, or physicians in practice have been ventured and found reasonably valid (at least on a standard of internal consistency) and reliable.[17] These include the rating of qualities by peers, colleagues in other disciplines (e.g. nurses), senior supervisors (including residents for students and faculty for students and residents), and patients. Self-rating approaches seem less apt to yield useful data. Louise Arnold has recently reviewed the large literature in this domain of instrument development for a joint, invitational meeting of the AAMC and the NBME [12] and in a related print publication.[48] On the basis of her review and my own reading of the literature I would conclude that a number of the instruments in use show reasonable psychometric properties, but substantial research will need to be done to establish the validity of the instruments more robustly and understand the myriad effects on such ratings of the situations in which they are generated (e.g., with greater or lesser first-hand exposure, in diverse care settings, by stage of education/training, by race and ethnicity of patients, etc.).[47,48] An especially thorny problem will be establishing the link between observer ratings, self assessments, and actual behavior in the crucible of stressful, conflicted situations. We will also need to show that generating and feeding back such data has positive educational effects, i.e. that it facilitates the professional growth and development of the individual being rated.

The most important question to resolve about measures of professionalism is not whether we can construct psychometrically sound instruments, but instead, whether we can do this in addition to devising the formative systems in which the use of multiple measures will facilitate professional growth and development of physicians in undergraduate education, graduate training, and in their careers.

In the end, we are not only interested in the reliability and validity of the observational and rating approach, but are also vitally interested in the *utility* of this whole undertaking for educational purposes. Suppose, for example, that a psychometrically sound rating instrument for 'integrity' were available - even one that had been validated against such external constructs as cheating on exams, copying one's patient write-ups from other persons' notes rather than personally evaluating the patient, being frequently late for patient care responsibilities in clinics, and/or failing to follow-up on tasks for patients and colleagues. The questions we would have about such an 'integrity instrument' in use would not only be about whether it generated valid and reliable data, but whether in the training context such data were useful in stimulating improvement in these behaviors. In fact, some of the most attractive approaches in this developmental area are those that focus explicitly on observable behaviors, instead of attempting to rate values or attitudes. This approach avoids the obvious difficulty involved in attempting to infer underlying attitudes from what a person may say or do. Instead, through a strategy of observation and reporting, the attempt is made to document problematic events that need remediation, whatever the underlying qualities of the individual might be that 'explain' such behaviors. If a student, resident, or physician is frequently late for his/her outpatient clinic sessions, this is a lack of accountable behavior that requires correction. At the outset, at least, it may not be important to know whether this problematic pattern of attendance is the result of forgetfulness, lack of respect for patients' time, inability to manage one's own time, or lack of easy transportation. Instead, if the observation, reporting and feedback strategy leads to recognition of the problem and the individual works to remedy it, the measurement strategy has worked and the educational utility has been demonstrated. Furthermore, under many circumstances it may be unimportant to create a measurement strategy that permits the identification of a specific problematic behavior. If a pattern of diverse dysfunctional behaviors in different circumstances emerges, even if the particular behaviors are quite unlike one another – for example, misrepresenting others' work as one's own, flashes of uncontrolled anger at support staff, and unaccounted absences - in a sentinel event recording strategy, this may be sufficient grounds to trigger a counseling session that includes open-ended inquiries about whether the individual recognizes that they are having difficulty, whether she/he understands the roots of these problems, and whether they could use assistance from others.[49,50]

The most important question to resolve about measures of professionalism is not whether we can construct psychometrically sound instruments, but instead, whether we can do this *in addition to devising the formative systems* in which the use of multiple measures will facilitate professional growth and development of physicians in undergraduate education, graduate training, and in their careers. The use of such instruments to qualify candidates for entry into the profession, or for summative evaluation, seems improbable at present. No instrument, as a 'threshold measure' taken alone is likely to be sufficiently discerning to use as certification tool, the kind of definitive 'litmus test' that would assure the NBME, a specialty boards organization, or a school of medicine that a candidate is, or is not, ready for graduation or certification. I would certainly not suggest that the NBME or the ABIM cease and desist in their efforts to develop measures of professionalism – quite the contrary – even if such measure are experimental in nature, the mere fact that these organizations are active in these domains will galvanize attention to professional development issues in undergraduate and graduate medical education. I hope, furthermore, that these 'high stakes' measurement organizations will debate whether we should focus our measures on individuals, organizations, or both. It is my view, however, that the professionalism measures will principally be useful as *formative* tools, a source of key information for feedback within a larger process of professional preparation.

How are we faring in the professional preparation of future physicians?

Be careful what you wish for

During my internship one of the clinical questions of special interest was whether there was any approach that might change the dismal prognosis of patients with severe liver disease and superimposed renal failure. The conventional belief was that the appearance of hepatorenal syndrome was tantamount to a death sentence. In our hospital, we had a special interest in plasma exchange, since this had been reported to awaken patients who had been in hepatic coma and might 'buy time' for the kidneys to make a functional recovery. In the absence of an intensive care unit, plasma exchange was accomplished by my bleeding the patient one unit at a time, running it up two floors to the blood bank where the red cells could be spun down, picking up the last unit of packed cells with some else's fresh frozen plasma, trotting down the stairs, and reinfusing the patient. This process was repeated as fast as possible and as long as possible to slowly approach, as Xeno could have appreciated, a maximally achievable state of total plasma exchange – or until the patient died, whichever came first. When a patient of mine was placed on this protocol, I was in the last of my three consecutive days of admitting. By the end of the day, it was clear that no cross-cover could hope to keep the exchange process going and handle their own admissions, so I stayed in to continue the process for another day – then another, and another. In the third day of exchange (and including one day of new admissions on top of the exchange for me) there was no change in the patient, but my vital signs were deteriorating. On that day, management of the patient's volume status grew more complicated because an upper GI bleed began and was shown to be attributable to esophageal varices. In the middle of the night, I recall standing in his room wearing a bloody scrub suit, looking at the red return from his balloon esophageal catheter, the units of plasma and packed cells I was running into him, and the phlebotomy bag filling from his other arm intravenous catheter - and wishing him dead.

To assess the present state of our achievements in the preparation of future professionals, we can turn to a research literature of modest volume, but of reasonably good quality. Whether one reviews qualitative (participant observer, in-depth interviewing, autobiographical) or quantitative survey work,[51,52,53,54,55,56,57] the picture that emerges from this research is a discouraging one. In fact, re-reading older ethnographic research suggests that the problems and challenges we face in preparing medical students for their careers has not changed much in the past 40-50 years. As they move through their undergraduate medical education experience, our students also move from being open-minded to being fact-surfeited, from being intellectually curious to being increasingly focused on just that set of knowledge and skills that must be acquired to pass examinations, from being open-hearted and empathetic to being emotionally well-defended, from idealistic to cynical about medicine, medical practice, and the life of medicine. This situation is far from what we as faculty would ever intend to create. Though I have not been able to find empirical research that documents whether or not the general

run of faculty are aware of this circumstance, I would not be surprised to learn - should such work ever be done - that we are not aware of what happens to students during their time among us. The "formative trajectory" of medical students is one that prepares them poorly for the kind of life commitment that we as faculty, given our ideals about professionalism in medicine, hope they make in their careers. I know that any such statement paints the scene with a too-broad brush but sadly, from my reading of the available literature and own experience as an educator, I do not think it is a substantial misrepresentation. I wish I could say otherwise.

The "formative trajectory" of medical students is one that prepares them poorly for the kind of life commitment that we as faculty, given our ideals about professionalism in medicine, hope they make in their careers.

If we as faculty, and even the somewhat beleaguered but ever-powerful role model residents, hold less cynical attitudes about the practice of medicine than students, how is it that this gulf persists? Here we come to the most ironic circumstance of all. In the very moments in which we might teach how our values express themselves in choices and actions, in the midst of situations that call upon our deepest values, *we fall silent.*[58] In our silence we miss the opportunities to initiate a discourse that would build our self-knowledge and create a community of learning around these difficult issues with peers and students, helping us all to learn.[59] And these moments are not rare. Here is one example. Think of times you have been on inpatient wards late in the evening, sitting in the doctors' office reading charts or writing notes. I wager you can remember listening to the residents and students work and becoming aware of their talk, whether or not they were members of your attending team. Then a patient buzzer begins to ring in the empty nurses' station – and ring and ring and ring – without a response. You know this probably means that someone, a patient or family visitor of a patient, needs help but also that it 'isn't your job' to respond to the call. Suppose you push a button to answer and the patient says that she needs to go to the bathroom. Do you promise to find the nurse, using your time in this fashion? Do you instead go to the room to see if you can assist the patient to the bathroom, with a bedside commode, or with a bedpan? By this time everyone in the room is aware of the incessant buzzing and is trying to decide what to do. You are aware of the tug of your conscience, but also aware of the waning hours of the day, and you continue to write your attending physician's note. This is as plain and ordinary an occasion as you can imagine – but it is also a critical incident, an opportunity for speaking, doing, teaching, and learning. In this situation you teach by whatever you do, something or nothing.

What we might say if we did speak in such circumstances is probably less important than whether or not we do say something. If we did nothing more than to let students know that we are working to keep our equanimity, this would be an advance over silence. Hearing nothing from us, students and residents can reasonably conclude that we simply are indifferent to someone's distress. The fact is quite the opposite. Every source of information I can find suggests that the lived experience of medicine is best characterized as a struggle. The circumstances into which we are thrust - because of the very nature of our work - challenge us, and this idealistic view of medicine, regularly.

Table 6. The Struggle to Stay Centered on Values in the Profession of Medicine.

Ideal	Foundational Value	Reality
Evidence-based	Truth/Science	Uncertainty
COI (confluence)	Therapeutic Alliance	COI (conflict)
Caring, healing	Curing	Risk-harming
Open heart/mind	Accepting, Empathic	Arrogant, unmoved
Error-free	Right action	Mistake-prone
Analytic	Reflective	Hassled, knee-jerk
Self-sacrificing	Altruistic	Avaricious

Students need to understand the struggle physicians experience at the center of a life in medicine, and the efforts we make to express our profession's ideals and values in action (Table 6). We value truth from scientific knowing and portray medicine as evidence-based practice, but know that the limits of evidence are always visible when making decisions about what to do in the single case and that 'cook-book medicine' is a danger, not a *desiderata*.[60,61] We seek to build therapeutic alliances with our patients through establishing a confluence of interests, but are also aware of the many conflicts of interest we encounter. When seeking to cure, we risk harm. When exercising openhearted empathy, we are vulnerable and sometimes injured by those we are seeking to help. Learning from this hard experience, we attempt to establish 'therapeutic distance' at the risk of appearing unmoved and arrogant. Though we value right action and hope to minimize errors, we know that we are error-prone in practice. We see (and describe) ourselves as analytic and reflective, but in daily circumstances seem to be hassled and engage in knee-jerk decision-making. While we aspire to altruism and see self-sacrifice as admirable under many circumstances, we appear to be intent on maintaining our income and perhaps avaricious. The ideals may be clearly identified, but the execution – the lived experience - is difficult. Between the intent and the deed often comes a conflict of virtues, and then a compromise, seeming far from the ideal. Seeing all of this difference between the ideals of medicine and our behaviors, and *hearing nothing from us* about the difficulties we face, the competing forces within the circumstances in which we work, the logic of the compromises we are making, and the intensity of the struggle to maintain our sense of integrity, students are left to their own devices, not even understanding how our view of our work and their view may differ.[62,63] The gulf between our students' experience and ours persists. We bequeath to them a fundamental misunderstanding of what we are doing, thinking, and feeling. If we can be so misunderstood by those closest to us, our students, how difficult must it be for the public to understand the connection between our values, rhetoric, and actions? From this perspective, it may not be surprising that we have lost so much trust among the general citizenry. If we are to serve future generations of physicians optimally and, beyond this first-order objective, seek to restore the trust of the public, what must we do?

Restoring Trust: How should we begin?

> ***Remedial learning.***
> I nearly failed several basic science requirements in the first year of medical school in the course of what would be described generously as a bumpy transition from the big concepts of a liberal arts education to the many, many specific facts of reductionistic science. Even worse was the fear on my part that both gross anatomy and neuroanatomy had been inadequately learned for the career that lay ahead. In a plan to patch this serious hole, I hatched a plan to enroll in summertime pathology elective between my second and third years. One of the strong features of this elective was the opportunity to conduct post-mortem examinations from initial gross dissections through all subsequent specimen cultures, standard histology, special stains, and final case summary. Early in the summer, I was carrying out the en-bloc removal of the abdominal organs with my preceptor, Dr. Sheldon, in all his Germanic tall rectitude standing behind me. I was doing a grisly tango with the bloc, holding the viscera close to my front as I tried to dissect the organs from the front of the vertebral column, when I perforated the stomach with my scalpel. I froze, as the abdominal cavity was suddenly flooded with gastric contents, obscuring all landmarks and limiting any further observations. From over my shoulder came the heavily accented voice of Dr. Sheldon. "Do you know, *Doctor* Inui, vaht is the differenz between you und me?" "No, I said in a small voice. " I', he said and paused, "I haf made *more* mistakes than you."

There can be no simple or simple-minded response to the question of how to begin to change the environment in which our students learn what professionals hold dear and seek to exemplify in their actions. If the most powerful learning is experiential, and students are close observers of the scene in academic health centers, essentially we as faculty are challenged to change what we think, say, and do as individuals and as members of a community. This kind of sea change will require no less than a shift of culture – what we together see as meaningful and important in our work lives.64 That's the bad news. The good news is that everything need not change at once and that starting anywhere, within any niche of institutional activity, has the potential to lead on to change elsewhere in the complex and highly interconnected organizational ecology of the academic health center, so long as the organizational leadership is attentive and facilitating this change 'from the top.' The natural history of organizational change can be described as problem recognition ('pain'), a vision of a different possible future ('cure'), and identification of small steps ('treatment') that lead in the direction of that future state. We have already described medicine's pain and what we are describing as our ideal vision of the virtuous professional in medicine. What are the steps that might lead in that direction within academic medical centers?

From the literature and my interviews of key stakeholders at the AAMC, a rich 'menu' of potential constructive actions emerges.

Table 7. Enhancing education for professionalism in medicine: Action agenda options

Enhance the recognition of the relevance of professionalism to key institutional roles and accountabilities.

- Make explicit the connection between professional values/behaviors and leadership development for Deans, Chairs, Chief residents
- Deans' actions to put professionalism, exemplary behaviors, monitoring, improvement, and feedback on the organizational agenda
- Develop an accreditation focus on professionalism curriculum
- "Broadband group" (LCME, ACGME, ABMS) deliberation of the potential for 'vertically integrated' emphasis on professionalism in accreditation
- NBME certification processes that permit broader assessment of knowledge/skills in domains relevant to professionalism

Make explicit the role of professionalism in organizational performance and management.

- Forge and implement a meaningful organizational 'code of ethics'
- Integrate professional norms for behavior into institutional missions, operations (e.g. with patient and staff reporting, feedback, hotlines)
- Seek input and collaboration for improving professional behaviors from multiple sectors of the academic medical center – nursing, patient care administration, support staff, patients/families, community
- Integrate the activities of clinical practice, teaching/learning, practice improvement and other functions into an organizational framework to create a community of professional work for education and training (e.g. a 'firm system')
- Use critical incident reporting as part of assessment of curriculum, professional development of trainees, and key information for institutional management
- Sponsor an explicit organization-community dialogue, develop guidelines for community engagement
- Create a visible source for helping resources for avoiding/resolving conflicts of interest, financial and other, within the academic medical center
- Create mechanisms for reviewing and taking action (remediation, probation, expulsion) on irremediable problem cases (student, faculty, staff) and disseminate summary information on these actions for discussion
- Create mechanisms for making exemplary behaviors/achievements more visible

Make explicit the role of professionalism in trainee/physician/program performance within the organization.

- Make explicit a focus on a candidate's history of meaningful service to others a component of medical school and residency applications (e.g. essay, interview)
- Measure and report meaningful content in the broad domain of professional qualities for the dean's assessment letter
- Discuss the medical school code of conduct (with focus groups of patients, staff, and faculty) annually in a process that focuses on a few specific, current challenges

- Create cases for discussion, as part of the code of conduct review, that are focused on students' and residents' ethical dilemmas (e.g. how to introduce myself when learning a new procedure, how to describe the procedure that will cause pain, how to deal with competition/evaluation pressures, cheating, abuse of drugs/alcohol by peers, time/responsibility conflicts, sexuality, gifts, racism, ageism, sexism, homophobia, reluctance to serve the poor/dirty/HIV-positive, etc.)
- Enhance ceremonial events that mark milestones in professional formation (e.g. white coat, first encounter with the cadaver, professional oath-taking)
- Educational outcomes assessment that features competency in broader professional domains (e.g. ACGME outcomes project, HMS 'New Pathway' assessment)

Enhance resources for continued learning and professional development in the hidden curriculum.

- Model positive professional behavior in the teacher/learner relationship (J Cohen's 'educational compact')
- Support community-based educational activities outside the academic medical center that are responsive to community needs and requests (e.g. service learning)
- Conduct morbidity and mortality conferences that avoid shame and humiliation, teach how to frame 'medical errors' constructively, and lead on to continuous improvement
- Expand professional dialogue to incorporate threats to professionalism (e.g. in clinical rounds, mentoring, trainee feedback, morbidity and mortality conferences, etc.)
- Develop enhanced mechanisms for focusing and remediating residency stress and burnout, personal and professional

Promote resources that make explicit the link between personal and professional growth and development.

- Research ethics training
- Implementation of professional/personal continuing development (e.g. ABIM)
- Medical humanities and social medicine courses – ethics, history, medicine/health/society
- Competency-driven curricula that specifically focus on 'professionalism'
- Evaluation measurement that focuses on 'lived experience' (e.g. critical incidents) for students and residents
- Qualitative methods (e.g. semi-structured debriefings) to assess "what's being learned?" in contradistinction to "what's being taught"
- Observational measures designed to generate formative feedback for students and residents on behaviors of related to professional values
- Mentoring programs for faculty and trainees broad enough in the scope of activities reviewed to reflect the wider scope of activities of the professional in medicine and which - in the relationship between the mentor and mentee - 'embody' the desirable qualities of the professional in medicine
- Professional development small groups (Balint groups) for undergraduate, graduate, and continuing medical education

- Patient and peer ratings of physician performance used for continuing professional development, especially those focused on physician trustworthiness and interpersonal skills
- Case studies for problem-based learning curricula that include threats to asserting positive professional qualities
- Teach the importance of uncertainty and open-mindedness in medicine
- Teach both the importance and limits of evidence-based medicine, as well as the continuing need for a natural science (systematic "nature watching") of health and health care.
- "Learning contracts" (specific learning agreements for periodic review and updating) for personal/professional growth for trainees
- Small group teaching/learning that includes, as a standard feature of group process, feedback on behaviors within the group that facilitate or inhibit individual and group functioning

Beyond the obvious emphasis on professional values and behaviors congruent with these values, what do the elements of this potential 'action agenda' have in common? There are several dimensions on which they are 'cut from one cloth.' *First*, the proposed actions acknowledge the importance of the many *relationships* between individuals and positions in the academic medical center that embody our culture and affect any strategic plan we might devise and implement. In our organizations many of these relationships are hierarchical in nature and must be in play for any systemic change to go forward. Deans, for example, may feel that they have limited new resources to 'fuel' organizational change, but certainly need to use their 'bully pulpit' and capacity to authentically convene, coordinate, and empower if a shift in organizational culture is intended among faculty and students. Other key relationships that may express and shape professional values and behaviors as well as mediate organizational change include those among all peers (clinical, research, educational), between patients and clinicians, between teachers and students, among residents and students, between the institution and its community, between the institution and its external stakeholders.[65] In each of these relational axes, there are opportunities for professional value-related dialogue, exercise of authority and power, choice making, and behaviors.[66] Authority and power to make change, as many have observed, do not necessarily flow together. Deans can articulate the intent to change the professionalism curriculum, for example, but the most powerful class of role-model teachers cited in critical incident learning are the residents whom students encounter in their clinical clerkships.

There can be no simple or simple-minded response to the question of how to begin to change the environment in which our students learn what professionals hold dear and seek to exemplify in their actions. If the most powerful learning is experiential, and students are close observers of the scene in academic health centers, essentially we as faculty are challenged to change what we think, say, and do as individuals and as members of a community.

A *second* dimension of commonality among the potential action agenda items is the emphasis on *behavior*, individual and organizational. Since the most powerful learning is produced by seeing and participating in *action*, we need to become particularly mindful and intentional about what we are doing and saying in day-to-day circumstances.[67] If we as faculty refer to teaching as an 'unfunded mandate,' the risk is that students – hearing us - may come to several unintended conclusions: our responsibility to them is mediated only or largely by money changing hands, we care more about financial than other incentives, we have a unrewarding relationship to the school, and we are teaching only reluctantly. Under these circumstances, if the chaos of our days makes us fifteen minutes late for a teaching session and we make a hassled appearance without apology or explanation, they see in our behavior a confirmation of all that they have inferred. If the medical school communications office regularly announces new major grants but never teaching innovations, by this behavior everyone understands that 'we' value scholarship in one sector of our mission (research) more than in others (education). Attending to behaviors that are physical, verbal, and symbolic will require explicit mindfulness of our professional values, 'fresh eyes' to see ourselves as others do, and an enhanced capacity to be reflective and articulate about what is happening. To teach and learn successfully in the domain of professionalism, as in other aspects of medicine as a 'performing field' (as Donald Schoen has noted) will require a synthesis of all of these capacities.[68] The infrastructure which supports this kind of synthesis will need to include the creation (or in some cases re-creation) of occasions and resources for teaching/learning that facilitate this kind of synthesis, such as opportunities for self-reflection[69,70,71,72,73] and even a reformed morbidity and mortality conference,[74] mentoring process, or educational outcomes measurement approach for formative feedback.

Acknowledging that the educational process in medicine changes - in some substantive sense - who we are as well as how we relate to others, may be the key to understanding why we need to be mindful, articulate, and reflective about the process.

Beyond individual and "educational infrastructural" change, our institutions themselves – by strategic shifts in their structure, altered use of resources, new choice of programs, improved employment practices, and more meaningful participation in the sociopolitical processes of their communities – will also have to manifest and embody the values we hope to exhibit as individual professionals in medicine.[75] At this point I should acknowledge, as perhaps the reader has already realized, that in this essay I have chosen to articulate the rationale and compelling need for individual transformation as key to education for professionalism. I have taken this approach because I believe that the institutional environments we create, through the work of our hands and minds or through the social/political policy that we affect, are a reflection of the values we hold as a professional community. On the other hand, I also know and acknowledge that individual change without organizational transformation is problematic at best. Clinicians striving to exemplify altruism and trustworthiness will find it impossible to succeed in this endeavor unless the whole fabric of their institution has been woven around such designs.[76] Whatever my personal intentions might be, I will be judged – in some important measure – by the qualities of the organization in which I work. In the end, I acknowledge the *interdependence* of indi-

vidual and organizational change and observe that our "action agenda" amounts to a strategy for organizational change, a strategy founded on professional values.

A *third* dimension on which the action agenda items find commonality – and the potential for synergy – is in an underlying view of the educational process as one best understood as personal and professional *formation*. Formation is a descriptive term in use in the educational literature (Parker Palmer)[77] but is more prominent in other helping professions (e.g. in the preparation of clergy). It refers to the process by which an individual *becomes* ('forms' as) the person who can successfully serve a calling - in the case of medicine to care for those with illness.[78,79] The processes of formation include experience and reflection, service, growth in knowledge of self and of the field, and constant attention to the inner life as well as the life of action. "Who am I *becoming* as I move towards this life of service?" is a critical question in formation, as disciplinary acculturation and expertise increases. Acknowledging that the educational process in medicine changes - in some substantive sense - *who we are* as well as *how we relate to others,* may be the key to understanding why we need to be mindful, articulate, and reflective about the process. It also highlights the risk of substituting technological expertise for knowledge of self in relationship to others and creating a scientific stance that imagines that self can be absent in a fundamental understanding of how decision making in medicine proceeds. Keeping considerations of self and professional together permits us to see work as an expression of self, and professional aspirations for trustworthiness and virtuous action as aspirations of our own heart. In a field that demands as much of us as medicine, anything less than this integration of person and professional may be unsupportable in the long run.

None of these actions taken alone would be expected to have a systemic effect unless it were a well-understood, visible part of a more comprehensive strategy of planned change. Clearly, many of the members of the academic community would have to be aware of such a professionalism initiative and, if not advocates, at least be open to the changes such an initiative might bring. That brings us to the *last* common feature of the items on the action agenda – they are unlikely to serve the overall strategy well unless we can become better able to discuss with one another what we are trying to do and why. This kind of discourse is not a strong suit of medicine. We tend to be more articulate when 'standing outside' a subject we are discussing and depersonalizing the opinions we express. This is part of the culture of biomedicine and one of the fundamentals of the logical positivistic stance of science.[80] If we are going, however, to speak of and act from our values, it will not be possible to do so while recusing our selves from the discussion. This will be a high-order challenge for us, but should facilitate everyone's learning – our own, our students', and our society's. Engaging in open discussion about how we think and feel as individuals about such matters as conflicts of interest, patient harm from medical errors, the challenges of care near the end of life, cloning, human experimentation, and many other matters will re-integrate personhood and professionalism, shed light on the choices we are making *in camera*, and through enhanced understanding encourage others to see us as trustworthy. This act of speaking from self is so close to attending to the moral core of our work that it has been described as a needed second principle for medicine. While the trustworthy profession would not want to set aside our first principle (*primum non nocere* - first do not harm), it may be that we need a second, companion principle *primum non tacere* (above all, be not silent).[81]

What individuals/organizations can take such an action agenda?

Finding community

In April, 1968 after Martin Luther King was shot dead, we stood in the dormitory windows as dusk gathered and watched Baltimore burn. A house staff family was camping on the floor of our suite's living room because it was not thought safe for them to remain in the quadrangle of their apartments ('the compound') at the edge of the medical campus. The Maryland National Guard arrived later, taking up positions around the perimeter of the hospital and dorms. It was time for choices. I thought my life would lie somewhere outside the perimeter, in the neighborhoods, so the next year my new wife and I became renters of a first-floor row house apartment two blocks away. The price was right, and we were young and could tolerate the noise from the autos in front and the trucks and drunks in the alley behind. When the bar on the corner finally closed at night, the whole scene got unruly, but the bars on our bedroom window and the steel security door at the back provided some assurance. Living there and in another row house eight blocks east over the next 5 years was an adventure. I was robbed twice on my way home from work at night, once by several kids with a knife and a second time by two young men with a gun and small pupils. I was never hurt, but I spent lots of energy 'reading the street', scanning the scene day and night as I walked to my destination, deciding when to cross to the other side, when to take another route, and when to turn around and retreat to the hospital or home. As a fellow, I undertook a project that required home visits to assess control and medication compliance among East Baltimore patients with high blood pressure. It was an eye-opener, even for a resident of the neighborhoods. For these study visits, I was in and out of the projects, condemned houses, bars, barbershops, laundromats, storefront churches, and vacant lots. I wore a white jacket at times and was looked after by patients, stoop sitters, ministers, school truants, and cops. I'm still amazed that the study was brought to completion and led on to other community-based approaches to hypertension control, in East Baltimore and elsewhere. The row houses in which we lived still stand, and the small tree we planted in front of the second home has become a distinctive feature of the block, shading the stoop on which we loved to sit.

Since a shift in culture is required to substantially affect education for professionalism in medicine, then no stakeholder in the community of medicine can be uninvolved in the change. All these individuals and organizations have much to contribute and much to gain from this participation. Either we all work together in assuring high professional standards and the trustworthiness of our institutions and ourselves - or we will all fail. As I write this account, the sorry story of corporate leadership and auditing accountants in some sectors in the United States threatens the trustworthiness of corporations and has exacted a huge toll on our national wealth. An egregious pattern of individual and organizational behavior among the priesthood has divided the Catholic Church from its membership and seriously eroded financing for the church's mission in the world. Breaches of trust in international affairs threaten the viability of peacemaking. Public and personal trust in the profession of medicine is a nec-

Since a shift in culture is required to substantially affect education for professionalism in medicine, then no stakeholder in the community of medicine can be uninvolved in the change.

essary precondition for caring and healing, and restoring this trust will require all of us – clinicians who take risks with patients because they believe that the chance of benefit should prevail in spite of the risk of litigation, investigators who contemplate conflicts of interests and take actions to avoid them in spite of the potential loss of a grant, teachers who decide to provide needed critical feedback to a student even if it is uncomfortable to do so, mentors who open the opportunity to discuss a protégé's commitments to family as well as career, administrative managers who when deciding what forms of productivity to reward take into account the need for time and flexibility in clinical care of the frail, financial managers who decide how 'noncognitive services' can be supported, accreditors who widen the scope of institutional self study to the aspects of academic community life that express professional values, examiners who decide that interpersonal competencies can be part of a measurement portfolio even if candidates' responses are used only for feedback instead of pass/fail decisions, students who decide to share credit for work achieved, residents who find the time on morning rounds to talk with dying patients in 'reverse isolation' and thereby model caring near the end of life, community practitioners who decide to volunteer time for teaching, professional organization members who advocate for the public's interest in public policy, health advocates who work for partnerships with academic health centers that serve minority populations as well as advance the community service mission of the institution, and many, many others. All stakeholders can make a contribution to strengthening the expression of professionalism in medicine.

Concluding comments – A flag in the wind

"The functional value of a body of specialized knowledge and skill is less central to the professional ideology than its attachment to a transcendent value that gives it meaning…"

Eliot Freidson [Professionalism: The Third Logic]

"One of the mysteries of illness is that no one can be healed by anyone whose emptiness is greater than their own."

Mark Nepo [The Dolphin Miracle][82]

On the "front stoop" of the twenty-first century, I doubt that those of us in medical education could make any more important resolution than to commit ourselves to improve our effectiveness in 'educating for professionalism.' In the long run, every contribution we can make to the health of the public, and I would warrant our satisfaction with our own lives and achievements, will hinge on our ability to

contribute to the positive qualities and trustworthiness of future physicians. Our highest aspiration may be to deserve a place in our society and culture as healers and virtuous, trusted professionals. However deep the insights and potent the technologies that emerge from our new biology, if we cannot be trusted to use them wisely as well as expertly, we will not serve the public good. Unless the physicians of the present and future can create stronger and more transparent relationships with their patients and their society, any actions they take as individuals and as a class of workers can and will be construed as a 'conspiracy against the laity.' For the good of all, we need to find the way to recover from this position of mistrust. Clearly, as in any relationship, we will not be able to accomplish this by ourselves. The public will need to recognize our effort and believe that we mean, as healers and professionals, to take whatever actions necessary to deserve their trust.

> ***Public and personal trust in the profession of medicine is a necessary precondition for caring and healing, and restoring this trust will require all of us***

As I have suggested earlier, there are many ways for us in medical education to take action, but to begin we at least need to share the recognition that a problem exists – and here, at last, we come to the metaphor of the flag in the wind. We think of flags as carrying meaning and signaling information. The flags that come to my mind are not white or flown at half-mast. It is not time for surrendering our professional aspirations in medicine, or mourning the death of a field. It would be a good time to fly storm warnings and to decide what 'colors' to fly, sound an *alarum*, declare who we are, and where our loyalties lie. Finally, from some Asian traditions comes the understanding that prayers - expressions of fervent wishes and aspirations for the present and future - can be written on flags and flown in the wind in hopes that the words will fly up to higher realms. The last meaning seems especially relevant when we contemplate the challenges that lie ahead as we seek to improve education for professionalism in these troubled times.

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