In search of professionalism: implications for medical education

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Abstract

This is the seventh article in an education series, discussing some of the ‘hot topics’ in teaching and learning in medicine. Historically, ‘professionalism’ was defined by the social structures of medicine, but has moved on to represent the expected behaviours and attributes of practitioners. Well publicised cases of professional misconduct, the rise of medical ethics as a discipline, and the move to a more patient-centred approach have driven the profile of professionalism into mainstream medical education. While there are many definitions of medical professionalism, there is a growing degree of consensus around what it encompasses; the way we manage tasks, our interactions with others, and looking after ourselves.

The literature indicates that professionalism can be taught, learnt and applied; that attributes and behaviours can be identified; and that assessment is best approached using a range of methods over time. For learners, one of the critical factors in developing professionalism is the modelling by senior members of the profession as students move from peripheral observers to legitimate participants. Medical programmes in New Zealand are engaging with this literature in developing current curricula.

Mention the word professionalism and each of us will conjure up phrases, events, encounters and perhaps individuals. Beyond those initial reactions, professionalism will mean slightly different things to each of us; we might find different ideas again if we asked our patients or fellow health professionals. While historical codes of practice illustrate the main - and reasonably stable - tenets of professionalism, the demonstration of professionalism in practice remains context and time specific.

This paper looks at more recent definitions and trends in professionalism, how professionalism is learnt and discusses whether it can be taught. We review how professionalism can be measured and assessed and suggest some areas for further exploration and curriculum development. We describe some of the initiatives being used by medical programmes in New Zealand to incorporate some of these concepts and approaches into curricula in order to nurture professionalism in future graduates.

How can professionalism be defined?

In the past, sociologists separated professional work from other occupations and defined a profession as a body of practitioners with a shared cluster of characteristics that set them apart. Friedson, who focussed much of his work on the medical profession, describes an ‘ideal-typical’ set of characteristics for a profession; specialised knowledge/skills, self control/regulation, division of labour, defined training pathway, monopoly and a code of ethics. He developed these core...
characteristics over 40 years and in the last iteration also included elements relating to discretionary power and autonomy.

A profession was defined by what made it distinct, how it was structured and how it interacted with society. The ‘founding fathers’ of western medicine also identified some of these features in their descriptions of an ideal physician, for example the ‘Hippocratic Oath’.

In the current practice of medicine, the emphasis has moved away from the sociological descriptions of structure and processes, towards the attributes of practitioners and how these are displayed as behaviour and actions. At first, the focus was on identifying negative attributes or the absence of certain behaviours: high profile cases of unprofessional practice highlight what was not said or done. Now, the emphasis is on promoting positive attributes.

It is suggested that the shift from defining what we are to defining how we practice has been driven by societal and technological change. Society seeks to hold the profession accountable, has access to information that was once the preserve of the profession and has both rebelled against and leveraged the consumerist model of health care that developed in the late 20th century.

Over the last decade, professionalism has emerged as an educational topic due to a number of drivers; the rise of medical ethics as a discipline; the societal shifts in attitude to the profession; and well publicised episodes of professional misconduct, internationally and locally. In response, medical programmes, colleges, and professional bodies have been industrious in developing and disseminating a wide range of definitions of professionalism, lists of desirable characteristics, and methods of assessment. Typical consensus characteristics are given in Figure1.

Figure 1. Typical characteristics of the domain of professionalism

- *Altruism*
- *Respect for others*
- *Honour, integrity, being trustworthy, probity*
- *Ethical and moral standards*
- *Accountability*
- *Striving for excellence (in relation to knowledge and skills)*
- *Duty, contribution, and societal responsibility*
- *Advocacy*
- *Compassion and empathy*
- *Being self-aware and reflective*
- *Self-resilience and self-care*
Currently, the espoused professional characteristics tend to be biased towards the non-cognitive domain: they encompass the way we manage tasks, our interactions with others, and looking after oneself as a health professional. It should be noted that these characteristics have been derived from within the profession: very little external validation exists. However, it is perhaps reassuring that when patients were asked about professionalism in a North American study, they tended to identify concordant behaviours, e.g. “pays attention to my concerns”, “speaks in terms I can understand”, “is compassionate”.

The difficulty for educators, is in translating these concepts and attributes into specific curricula. It is all very well giving a profound lecture on the expectations of society, but students need to learn to embody such characteristics within their own professional development; the gap between theory and practice is still a large one.

**How is professionalism learnt?**

Students bring with them traits, attitudes, and prior experiences. However, these are often still in flux and are malleable; typically medical students start training in their late teens and early 20s. Where programmes use interviews as part of selection (undergraduate or postgraduate specialist training), one objective is to select students with evidence of some of the positive professional attributes that we seek to grow and develop.

The ‘culture’ of medicine then becomes the biggest influence. In the late 1950s, Becker and colleagues studied the cultural change that medical students went through in their journey to becoming doctors. Unfortunately the predominant culture was often negative, including displays of elitism and cynical attitudes. More recently the concepts of ‘legitimate peripheral participation’ and ‘communities of practice’ provide a more accessible and pragmatic framework for examining how students learn to ‘become’ a health professional. These texts acknowledge and incorporate the importance of peer and senior pressure and role-modelling on the development of professional identity: elements of what has become known as the ‘hidden curriculum’.

The hidden curriculum, that which is experienced rather than generated or endorsed by Faculty, has been recognised since the 1950s as an alternative but influential process at work within medical education, affecting the development of professional values. The hidden curriculum has been described as having a more powerful influence than the explicit curriculum: It is the sum of unwritten rules, influences and attitudes that students acquire initially from other students within medical school, and later from doctors in clinical settings.

It has been suggested by Crandall and colleagues that the hidden curriculum may serve to erode humanistic qualities that are deemed essential to the delivery of high quality care; qualities endorsed by medical education facilities worldwide. By first recognising that the hidden curriculum exists, and later by appreciating the influence that it exerts, one can start to change the hidden curriculum itself, turning it into a positive influence on the novice student. Two American medical students, writing in *Academic Medicine*, identify the key barriers to successful professionalism education being the unprofessional conduct of those that the students learn from.
Some schools have sought to redress this through deliberate positive role-modelling in the early years within all levels of an institution, described as an “inoculation”.

The effect of role-modelling cannot be understated. Students learn what they see modelled in the professional domain. Thus, the mantra of “see one, do one, teach one” has a similar, if not more powerful role for professionalism. Hatem has worked with residents as teachers and observed that “caring for the learner and caring for the patient reflect identically parallel professional skills”.

Can professionalism be taught?

Teaching methods and curriculum approach—As professionalism began to appear on the curriculum agenda in the mid/late 1990s, schools included formal teaching in this domain as well as identifying ways of making experiential learning explicit. In the USA, an audit of professional curricular content in 1998 indicated that there were large differences between schools. This was true of most other Western settings at the time.

The assumption that students would learn professional behaviours solely on the basis of serendipitous clinical experience and clinical supervision was now being challenged. However, the response to increased teaching of professionalism using didactic methods has not necessarily produced the desired results indicating that professionalism needs to be applied, modelled and assessed, and not simply taught.

Within this applied approach, two distinct curriculum frameworks arose; one content-based, using the endorsement of aspirational traits; the other outcomes-based using observation of practical behaviours.

The rise in use of small group learning in medical education now provides an early context for developing, applying and assessing professionalism; students are required to work together, their contribution and collaboration can be assessed, and there are opportunities to encourage self-awareness, individual responsibility, respect for others, and reflective skills.

Barriers in the curriculum—The main barriers are the variable role-modelling and negative acculturation experiences (the process of assimilating oneself into a new cultural setting or group). These arise throughout training, are recognised globally and the impact is perhaps most significant when learning in the authentic clinical environment. Looking at the local New Zealand setting, variable, disruptive, and unprofessional behaviour have been identified and reported in clinical learning environments. Furthermore, students work with many clinicians and health professionals who are not university employees and who are not provided with coaching on how to teach or to be role models for their attending students. When faculty and other doctors are already overloaded in their clinical duties and find teaching to be an added burden, students can find themselves marginalised or excluded. This may negatively impact on their learning about patients and how to work with others.

Assessment of professionalism

Principles and measurement tools—Some general principles of assessment and best practice need to be considered from the outset. When considering competence, we
need to view this as a journey in developing and demonstrating correct and appropriate habits and skills (performance); the role of the context; the importance of deliberate practice; and the importance of reflection. In terms of tools and methods, using a range of assessments over time is a sensible pragmatic approach allowing for the capture of different sorts of data and the balancing the pros and cons of different methods.²⁵–²⁷

This complexity in measurement is reflected by over 90 different methods of assessing professionalism that have been described in the literature.²⁸ The tools commonly described include peer and self assessment, OSCEs (Objective Structured Clinical Examinations), direct observation, critical incident reports, portfolios, standardised checklists, and reflective narratives.²⁷,²⁹

Limitations of the various tools need to be considered when planning assessments. For example difficulties arise if the assessment attempts to measure competence in a controlled setting (i.e. OSCE) and then extrapolates this to actual performance in practice.²⁷ Another issue is that there are likely to be lapses in professionalism for any individual; thus single observations can be over-interpreted by teachers, generalised and create an attribution bias. Assessment over time should ameliorate this and allow for appropriate support, mentoring, feedback and remediation if necessary.²⁷,²⁸

Best practice in assessment suggests that we should be making more use of authentic contexts (in practice) and engage a range of observers (e.g. ‘360 degree’ approaches or multi-source feedback), including peers.²⁶ Peers may be best placed to assess professionalism as individuals may act differently when not under scrutiny.³⁰ There is also support for not just examining behaviour.

Rees and Knight discuss the fact that Faculty may ‘pass’ students with professional behaviours but unethical attitudes, and ‘fail’ students with unprofessional behaviours but ethical attitudes.³¹ They propose that all plans to assess professionalism should include both observational data and an interview or ‘conversation with a purpose’³²; a discussion with the learner about their observations and reflections on their own performance.

It is also argued that context is critically important and that labelling a student as ‘unprofessional’ on one incident (rather than an episode of unprofessional performance), without taking into account the context and other related circumstances, is inherently suspect.³¹ So it is appropriate, within the constraints of feasibility, to increase the frequency and depth of observations of students or trainees in a variety of settings to improve the confidence that we have in summative assessments of professionalism.

Before any assessment plan is developed, it is also critical to address the purpose of the assessment: this could include selection of applicants, removing those unfit for practice, providing anonymous feedback, or determining if a programme is effective in teaching professionalism.²⁸ The purpose will affect the choice of assessment methods, e.g. peer assessment works well when assessing formatively but is more open to subversion when the stakes are higher.

Stern recommends that separate and independent systems are used for formative (for feedback on progress, but not for judgement) and summative (for decisions about
progress or certification) assessments, although an assessment can perform both functions.

Impact on practice—We are too early in the educational cycle to be able to measure the impact of explicit professionalism teaching and learning on practice. There is some retrospective evidence that early fitness to practice issues relate to ongoing professional issues, particularly with respect to ‘irresponsibility’, and ‘diminished ability to improve’. In a US study, failure to complete evaluations or required immunisations in the pre-clinical years—encompassing aspects of integrity, duty, and self care—were significant predictors of identified unprofessional behaviour in clinical practice.

Assessment summary—Any assessment plan needs to include a clear purpose, summative and formative assessment components, and a variety of different methods over time. In general, multiple assessment opportunities over time, using different approaches, produces a clearer impression of performance than a smaller number of higher stakes assessments.

There should be attention to the context and the assessment plan must allow exploration of underlying attitudes as well as behaviour. Existing tools need further refinement and additional tools are required to measure outcomes that are not covered, particularly to assess observed performance in authentic clinical settings. As highlighted in the literature, an inadequate system of feedback, mentoring and remediation will undermine any well thought out assessment plan.

The New Zealand perspective

The Auckland and Otago medical programmes have developed curricula in the professional domain in recent years, the emphasis being both on theory and the application to practice.

Professionalism is addressed through lectures, small groups, and experiential learning across the programmes; the scene being set in the first week of students’ experience. Training in clinical skills now starts immediately and includes interviews and interactions with real and simulated patients in both medical school and community contexts. The marriage of skills with the development of professional attributes is made explicit: self reflection forms an important part of communication skills assessments. Small group learning activities also emphasise professional attributes.

At Auckland University, year 2 & 3 students receive formative and summative feedback on their group roles and contribution. Whole class ethics teaching is reinforced with small group activities where personal and societal issues can be explored.

Integrated learning activities (ILAs), introduced at Auckland in 2009, contextualise professional issues in the exploration of a clinical case. For example, the ‘Cancer Continuum’, a video documentary of the patient journey, raises issues of ethics, empathy, advocacy and accountability; in the ‘Human Early Life and Development’ project, pairs of students visit a family and observe the development of an infant within its family context, raising a number of professional development issues. A ‘Population Health Intensive’ in year 5 provides an interprofessional team-working context to focus on duty, contribution, and societal responsibility.
At Otago University, year 2 students now do 20 hours of work in rest-homes as assistant caregivers. Personal reflection is part of the assessment and there is the opportunity to begin experiencing core professional values such as altruism, respect, integrity, and compassion. Community placements in year 3 provide opportunities for inter-professional learning, exposure to the ethos of palliative care and hospice facilities.

Other innovations have been electives in the humanities as well as some initial study on the history and development of the modern biomedical method. The year 5 rural immersion scheme has been popular and highly successful; students are required to combine knowledge based learning with the necessary professional attitudes for rural work.

Medical schools around the world are now including reflective skills as a core competency; for example, written assignments may require students to articulate how and what they have learned as well as what they need to work on further—the formative nature being crucial. The long-term goal is self-aware practitioners who can identify their ongoing learning needs. There is also considerable concern about the health of medical students and increasing research linking doctors’ health to patient outcomes. These concerns give faculty a mandate to provide students with methods of self-care.

Simply giving them the facts on the occupational hazards of medicine as a career or the links between doctor health and patient outcomes, is not sufficient. Both New Zealand programmes are now looking at specific training in ‘Mindfulness’ (a form of meditative that has developed into a stress reduction approach and behavioural therapy) along the lines of both Harvard (USA) and Monash (Australia) Medical Schools. At present, relaxation and stress reduction activities are experienced and learnt as part of small group activities in Auckland, complemented by a web resource and a reflective stress diary.

These initiatives in reflective practice and self-care are presently confined to the first few years in medical school. We strongly believe however, that they now need to also be extended into the clinical years and beyond that, into specialty training.

**Conclusion**

The concept of the ‘professional’ has its roots in the historical description of how a group of practitioners organise themselves within society. This is now an unhelpful definition and in modern times when considering professionalism we think of the activities and behaviours of the professional. In medicine, the common themes are; altruism, a code of ethics, societal responsibility and humanistic values (e.g. honesty, compassion and respect).

Contemporary concepts of professionalism are concerned with the interface between the practitioner and the constellation of people involved in delivering health care. The focus on learning about, developing and demonstrating professionalism reflects the current understanding that professional expertise includes and emphasises attitudes as much as knowledge and skills. In terms of assessment, there is no perfect recipe; but good evidence exists in the literature for the planning, implementation and design of assessments.
This article has focussed on medical education, but parallel changes have been seen in other health professions. These changes have helped to drive some additional professional characteristics that focus on collaboration and care delivery such as skills for multi-professional team-working and ensuring patient safety.

Professionalism is about both nature and nurture. Practitioners and students bring personality traits, attributes and experience that can positively influence our learning and practice. The converse is also true. Through behaviour and activity, members of the profession can display these characteristics. Our role as teachers and clinicians, within the settings in which we work and learn is to nurture the positive professional behaviours in ourselves and others.

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