Resources for Teaching Professionalism

Provided to participants in FMF 2019 session entitled _Professionalism: Encouraging exemplary behavior and remediating lapses (#T448)._ Compiled by Dr. Wayne Weston, October 2019

Web Resources:

Advancing Education in Medical Professionalism. An Educational Resource from the ACGME Outcome Project – Enhancing residency education through outcomes assessment, 2004. Available at https://www.southalabama.edu/colleges/com/gme/resources/medical-professionalism-faculty.pdf Accessed October 9 2019.

 The American Board of Pediatrics & The Association of Pediatric Program Directors: Teaching, Promoting and Assessing Professionalism Across the Continuum: A Medical Educator's Guide (2016). A 76-page comprehensive guide. Available at https://www.abp.org/sites/abp/files/pdf/professionalism.pdf. Accessed October 9 2019.

Berwick D: "Let Era 3 Be the Moral Era". A 7-minute discussion of 9 steps to the moral era in healthcare. Available at https://www.youtube.com/watch?v=H2SoHLHufv4. Accessed October 9 2019.

* CanMEDS 2015. Available at http://canmeds.royalcollege.ca/uploads/en/framework/CanMEDS%202015%20Framework_EN_Reduced.pdf Accessed October 9 2019. See especially pages 15-16 on the role of Professional.

* CMPA Good Practices Guide on Professionalism. Fabulous resource on many aspects of professionalism – well designed and interactive. Available at https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/professionalism/professionalism-e.html. Accessed October 9 2019.

Cruess RL, Cruess SR, Snell L, et al: _Teaching, Learning and Assessing Professionalism at the Post Graduate Level_. Resource # 20 from the Environmental Scan for the Future of Medical Education in Canada Postgraduate Project, 2011. Available at http://www.afmc.ca/pdf/fmec/20_Cruess_Professionalism.pdf October 9 2019.

The AFMC EPA Working Group: AFMC Entrustable Professional Activities for the Transition from Medical School to Residency. Available at

https://afmc.ca/sites/default/files/documents/AFMC_Entrustable_Professional_Activities_EN_0.pdf Accessed October 9 2019.

Gliatto P, Stern D: Not Fit to be a Doctor: a Debate on Medical Professionalism and High Stakes Educational Decisions. Available at https://www.youtube.com/watch?v=sEtbuHSCH_I Accessed September 5 2017. Discussion of a case of a medical student dismissed just weeks before graduation for lack of professionalism.

* Inui TS: *A Flag in the Wind: Educating for Professionalism in Medicine*. Washington: Association of American Medical Colleges, 2003. Available at http://users.clas.ufl.edu/msscha/Readings/flaginthewind_professionalism_med.pdf Accessed October 9 2019.

American Board of Internal Medicine: Medical Professionalism & The Physician Charter. Available at http://abimfoundation.org/what-we-do/medical-professionalism-and-the-physician-charter Accessed October 9 2019. This site has links to many valuable resources on professionalism including A Physician Charter.

The LIFE Curriculum (Learning to Address Impairment and Fatigue to Enhance Patient Safety. Available at http://med.stanford.edu/gme/duke_life/ Accessed October 9 2019.

VITALS – Be Well. A student run initiative to promote wellness in all years of undergraduate training by students at the Schulich School of Medicine and Dentistry. Available at http://westernvitals.ca Accessed October 9 2019. Related resources from Western Universityare available on Twitter at https://twitter.com/WesternVitals Accessed October 9 2019.

Books:

Cooke M, Irby DM, O'Brien BC: *Educating Physicians – A Call for Reform of Medical School and Residency*. San Francisco: Jossey-Bass, 2010.

*Cruess RL, Cruess SR, Steinert Y (Editors): *Teaching Medical Professionalism: Supporting the Development of a Professional Identity, 2nd edition*. New York: Cambridge University Press, 2016.

Fenwick T: *Professional Responsibility and Professionalism: A Sociomaterial Examination*. New York: Routledge, 2016.

Hafferty FW, O'Donnell JF (Editors): *The Hidden Curriculum in Health Professional Education*. Hanover, New Hampshire: Dartmouth College Press, 2014. See especially chapter 15: Professionalism, Professional Identity, and the Hidden Curriculum: Do As We Say and As We Do by Richard L and Sylvia R Cruess.

Kalet A, Chou CL (Editors): *Remediation in Medical Education: A Mid-Course Correction.* New York: Springer, 2014. See especially chapter 7: Remediating Lapses

in Professionalism by Muriel J Bebeau and Kathy Faber-Langendoen. See also chapter 15: Feedback and Remediation: Reinforcing Strengths and Improving Weaknesses by Denise M Connor, Calvin Chou and Denise L Davis.

* Levinson W, Ginsburg S, Hafferty F. Lucey CR: *Understanding Medical Professionalism.* New York: McGraw-Hill Education, 2014.

Stone D, Heen S: *Thanks for the Feedback – the Science and Art of Receiving Feedback Well.* New York: Penguin Books, 2015.

Journal Articles:

Birden H, Glass N, Wilson I, et al: **Teaching professionalism in medical education: A best evidence medical education (BEME) systematic review**. BEME Guide No. 25. *Medical Teacher*. 2013;35:e1252-e1266.

> **Introduction**: We undertook a systematic review to identify the best evidence for how professionalism in medicine should be taught.
> **Methods**: Eligible studies included any articles published between 1999 and 2009 inclusive. We reviewed papers presenting viewpoints and opinions as well as empirical research. We performed a comparative and thematic synthesis on all papers meeting inclusion criteria in order to capture the best available evidence on how to teach professionalism.
>
> **Results**: We identified 217 papers on how to teach professionalism. Of these, we determined 43 to be best evidence. Few studies provided comprehensive evaluation or assessment data demonstrating success. As yet, there has not emerged a unifying theoretical or practical model to integrate the teaching of professionalism into the medical curriculum.
> **Discussion**: Evident themes in the literature are that role modelling and personal reflections, ideally guided by faculty, are the important elements in current teaching programmes, and are widely held to be the most effective techniques for developing professionalism. While it is generally held that professionalism should be part of the whole of a medical curriculum, the specifics of sequence, depth, detail, and the nature of how to integrate professionalism with other curriculum elements remain matters of evolving theory.

Boudreau JD, Macdonald ME, Steinert Y: **Affirming professional identities through an apprenticeship: insights from a four-year longitudinal case study**. *Academic Medicine.* 2014;89(7):1038-1045.

> **Purpose:** A four-year course, entitled Physician Apprenticeship, was introduced at McGill University's Faculty of Medicine in 2005. The primary objective of the course is to assist students in their transition from laymen to physicians. The goal of this study was to understand the apprenticeship learning process, particularly its contribution to professional identity formation.
> **Method:** For data collection, the authors used a longitudinal case study design with mixed methods. They conducted the study over a four-year curricular cycle, from 2008–2009 to 2011–2012. The case consisted of three apprenticeship groups. Students (n = 24) and teachers (n = 3) represented two subgroups for data analysis.

Results: Physician Apprenticeship activities promoted and sustained medical professionalization in the participants. Salient features of successful apprenticeship learning were access to authentic clinical experiences as well as the provision of a safe learning environment and guided critical reflection. The latter two ingredients appear to be mutually reinforcing and contributed to the creation of meaningful student– teacher relationships. Teachers exhibited several qualities that align with a parental role. Students became increasingly aware of having entered the kinship of physicians. Teachers experienced a renewal and validation of their commitment to the ideals of medicine.

Conclusions: Findings strongly suggest that a longitudinal apprenticeship in an undergraduate medical program can contribute to the formation and reaffirmation of professional identity. The case study design permitted the authors to create a provisional conceptual model explicating important features of the apprenticeship learning process.

Coulehan J, Williams PC: **Vanquishing virtue: the impact of medical education.** *Academic Medicine*. 2001;76:598-605.

North American physicians emerge from their medical training with a wide array of professional beliefs and values. Many are thoughtful and introspective. Many are devoted to patients' welfare. Some bring to their work a broad view of social responsibility. Nonetheless, the authors contend that North American medical education favors an explicit commitment to traditional values of doctoring—empathy, compassion, and altruism among them —and a tacit commitment to behaviors grounded in an ethic of detachment, self-interest, and objectivity.

They further note that medical students and young physicians respond to this conflict in various ways. Some re-conceptualize themselves primarily as technicians and narrow their professional identities to an ethic of competence, thus adopting the tacit values and discarding the explicit professionalism. Others develop non-reflective professionalism, an implicit avowal that they best care for their patients by treating them as objects of technical services (medical care).

Another group appears to be ''immunized'' against the tacit values, and thus they internalize and develop professional virtue. Certain personal characteristics of the student, such as gender, belief system, and non-medical commitments, probably play roles in ''immunization,'' as do medical school features such as family medicine, communication skills courses, medical ethics, humanities, and social issues in medicine. To be effective, though, these features must be prominent and tightly integrated into the medical school curriculum.

The locus of change in the culture of medicine has now shifted to ambulatory settings and the marketplace. It remains to be seen whether this move will lessen the disjunction between the explicit curriculum and the manifestly contradictory values of detachment and entitlement, and the belief that the patient's interest always coincides with the physician's interest.

Coulehan J. **Viewpoint: Today's professionalism: Engaging the mind but not the heart.** *Academic Medicine*. 2005;80:892–898.

Professionalism is au courant in medicine today, but the movement to teach and evaluate professionalism presents a conundrum to medical educators. Its intent is laudable: to produce humanistic and virtuous physicians who will be better able to cope with and overcome the dehumanizing features of the health care system in the United States. However, its impact on medical education is likely to be small and

misleading because current professionalism curricula focus on lists of rules and behaviors. While such curricula usually refer to virtues and personal qualities, these are peripheral because their impacts cannot be specifically assessed.

The author argues that today's culture of medicine is hostile to altruism, compassion, integrity, fidelity, self-effacement, and other traditional qualities. Hospital culture and the narratives that support it often embody a set of professional qualities that are diametrically opposed to virtues that are explicitly taught as constituting the "good" doctor. Young physicians experience internal conflict as they try to reconcile the explicit and covert curricula, and they often develop non-reflective professionalism. Additional courses on professionalism are unlikely to alter this process. Instead, the author proposes a more comprehensive approach to changing the culture of medical education to favor an approach he calls narrative-based professionalism and to address the tension between self-interest and altruism. This approach involves four specific catalysts: professionalism role-modeling, self-awareness, narrative competence, and community service.

Cruess SR, Cruess RL, Steinert Y: **Role modeling making the most of a powerful teaching strategy**. *BMJ*. 2008;336:718-721.

As teachers we are capable of wide variation in our performance as role models, and we can demonstrate both positive and negative behaviours in a single encounter, as illustrated in the first vignette (box 1).
The characteristics of role models have been well documented1 3 4 8-10 (fig 2) and can be divided into three categories:

Clinical competence encompasses knowledge and skills, communication with patients and staff, and sound clinical reasoning and decision making. All of these skills must be modelled as they lie at the heart of the practice of medicine.

Teaching skills are the tools required to transmit clinical competence. A student centred approach incorporating effective communication, feedback, and opportunities for reflection is essential to effective role modelling.

Personal qualities include attributes that promote healing, such as compassion, honesty, and integrity. Effective interpersonal relationships, enthusiasm for practice and teaching, and an uncompromising quest for excellence are equally important.

* Cruess RL, Cruess SR, Boudreau JD, Snell L, Steinert Y: **A schematic representation of the professional identity formation & socialization of medical students & residents.** *Academic Medicine* 2015;90(6):718-725.

Recent calls to focus on identity formation in medicine propose that educators establish as a goal of medical education the support and guidance of students and residents as they develop their professional identity. Those entering medical school arrive with a personal identity formed since birth. As they proceed through the educational continuum, they successively develop the identity of a medical student, a resident, and a physician. Each individual's journey from layperson to skilled professional is unique and is affected by "who they are" at the beginning and "who they wish to become." Identity formation is a dynamic process achieved through socialization; it results in individuals joining the medical community of practice. Multiple factors within and outside of the educational system affect the formation of an individual's professional identity. Each learner reacts to different factors in her or his own fashion, with the anticipated outcome being the emergence of a professional identity. However, the inherent logic in the related processes of professional identity

formation and socialization may be obscured by their complexity and the large number of factors involved.

Drawing on the identity formation and socialization literature, as well as experience gained in teaching professionalism, the authors developed schematic representations of these processes. They adapted them to the medical context to guide educators as they initiate educational interventions, which aim to explicitly support professional identity formation and the ultimate goal of medical education—to ensure that medical students and residents come to "think, act, and feel like a physician."

Doja A, Bould MD, Clarkin C, et al: **The hidden and informal curriculum across the continuum of training: a cross-sectional qualitative study**. *Medical Teacher*. 2016;38:410-418.

Purpose: The hidden and informal curricula refer to learning in response to unarticulated processes and constraints, falling outside the formal medical curriculum. The hidden curriculum has been identified as requiring attention across all levels of learning. We sought to assess the knowledge and perceptions of the hidden and informal curricula across the continuum of learning at a single institution.
Methods: Focus groups were held with undergraduate and postgraduate learners and faculty to explore knowledge and perceptions relating to the hidden and informal curricula. Thematic analysis was conducted both inductively by research team members and deductively using questions structured by the existing literature.
Results: Participants highlighted several themes related to the presence of the hidden and informal curricula in medical training and practice, including: the privileging of some specialties over others; the reinforcement of hierarchies within medicine; and a culture of tolerance towards unprofessional behaviors. Participants acknowledged the importance of role modeling in the development of professional identities and discussed the deterioration in idealism that occurs.
Conclusions: Common issues pertaining to the hidden curriculum exist across all levels of learners, including faculty. Increased awareness of these issues could allow for the further development of methods to address learning within the hidden curriculum.

Fenwick T: **Social media and medical professionalism: rethinking the debate and the way forward.** *Academic Medicine*. 2015;89(10):1331-1334.

This Perspective addresses the growing literature about online medical professionalism. Whereas some studies point to the positive potential of social media to enhance and extend medical practice, the dominant emphasis is on the risks and abuses of social media. Overall evidence regarding online medical professionalism is (as with any new area of practice) limited; however, simply accumulating more evidence, without critically checking the assumptions that frame the debate, risks reinforcing negativity toward social media. In this Perspective, the author argues that the medical community should step back and reconsider its assumptions regarding both professionalism and the digital world of social media. Toward this aim, she outlines three areas for critical rethinking by educators and students, administrators, professional associations, and researchers. First she raises some cautions regarding the current literature on using social media in medical practice, which sometimes leaps too quickly from description to prescription. Second, she discusses professionalism. Current debates about the changing nature and contexts of professionalism generally might be helpful in reconsidering notions of online medical professionalism specifically. Third, the author argues that the virtual world itself and its built-in codes deserve more critical scrutiny. She briefly summarizes new research from digital studies both

to situate the wider trends more critically and to appreciate the evolving implications for medical practice. Next, the author revisits the potential benefits of social media, including their possibilities to signal new forms of professionalism. Finally, the Perspective ends with specific suggestions for further research that may help move the debate forward.

Increasingly, researchers are studying professionalism as a collective endeavor embedded within complex systems. For example, Martimianakis and colleagues show how a simple direction to a clinical clerk from her emergency department supervisor that she conduct a quick internal vaginal examination of a pregnant patient in a busy hallway integrates multiple conflicts of professionalism: patient-centered care, resource constraints, historic institutional conflicts and practice, hierarchies, gender and race, and the different roles demanded of doctors (problem solver, humanist, teacher, colleague, advocate, cooperative employee). All of these issues speak to a more systemic, relational, and even pluralist approach to understanding professionalism. Certainly, the networked context of social media in itself challenges an isolated focus on the behaviors of individual professionals.

Gill D, Griffin A, Launer J: **Fostering professionalism among doctors: the role of workplace discussion groups.** *Postgraduate Medical Journal.* 2014;90:565-570.

Background: The professionalism of doctors has come in for increasing scrutiny and discussion, within the profession and in society. Professionalism has also become of central interest in undergraduate and postgraduate medical education. There is a great deal of debate about the nature of medical professionalism, how to promote it and what approaches to learning are most effective.

Objective: This study aims to identify the role of workplace-based discussion groups in encouraging and supporting the development of professionalism among doctors.

Methods: Workplace-based discussion groups including doctors from all non-consultant grades and specialties were established in five hospitals over a 6 month period in 2010–2011. A mixed-methods approach was used to identify the perceived impact of these groups on participants, which included interviewing the group facilitators and education leaders at participating hospitals. Results Understanding of professionalism at an individual level was improved along with an increased awareness of the collective nature of professionalism in everyday clinical practice. Key to the success of the groups was the creation of a legitimate space to explore professionalism and professional challenges and the use of experienced facilitators who could build trust in the groups.

Conclusions: A purely individualistic approach to professionalism does not resonate with contemporary, team-based healthcare. Work-based groups can provide a focus for an approach to professionalism that is mindful of self, the team, the culture and the organisation. This evaluation provides guidance to a range of stakeholders on how to develop educational interventions that foster professionalism, personal and collective, and offers some pointers towards the range of factors that may impact on the outcomes of such activities.

Goldie J: **Assessment of professionalism: A consolidation of current thinking**. *Medical Teacher*. 2013;35:e952-e956.

Context: Professionalism has become a hot topic in medical education. Professionalism needs to be assessed if it is to be viewed as both positive and relevant.

Objectives: The assessment of professionalism is an evolving field. This review aims to consolidate current thinking. Implications: Assessment of professionalism has

progressed from an initial focus on the development and attainment of professional identity, through identifying areas of deficiency, to the attainment of a set of identifiable positive attributes and behaviours. It is now beginning to recognise the challenge of assessing a multi-dimensional construct, looking beyond the measurement of behaviour to embrace a diversity of approaches.

Conclusions: Professionalism should be assessed longitudinally. It requires combinations of different approaches, assessing professionalism at individual, interpersonal and societal/institutional levels. Increasing the depth and the quality of reliability and validity of existing programmes in various contexts may be more appropriate than concentrating on developing new instruments. Increasing the number of tests and the number of relevant contexts will increase the reliability of the result. Similarly increasing the number of observers increases reliability. Feedback, encouraging reflection, can promote change in behaviour and identity formation.

Green M, Zick A, Makoul G: **Defining professionalism from the perspective of patients, physicians, and nurses.** *Academic Medicine*. 2009;84:566-573.

Purpose: Although professionalism has always been a core value in medicine, it has received increasingly explicit attention over the past several years. Unfortunately, the terms used to explain this competency have been rather abstract. This study was designed to identify and prioritize behaviorally based signs of medical professionalism that are relevant to patients, physicians, and nurses.

Method: The qualitative portion of this project began in 2004 with a series of 22 focus groups held to explore behavioral signs of professionalism in medicine. Separate groups were held with patients, inpatient nurses, outpatient nurses, resident physicians, and attending physicians from different specialties, generating a total of 68 behaviorally based items. In 2004–2006, quantitative data were collected through national patient (n=415) and physician leader (n=214) surveys and a statewide nurse (n=237) survey that gauged the importance these groups attach to the behaviors as signs of professionalism and determined whether they are in a position to observe these behaviors in the clinical setting.

Results: The surveys of patients, physician leaders, and nurses provided different perspectives on the importance and visibility of behavioral signs of professionalism. Most of the behaviors were deemed very important signs of professionalism by at least 75% of patients, physicians, and/or nurses; far fewer were considered observable in the clinical setting.

Conclusions: This study demonstrates that it is possible and instructive to define professionalism in terms of tangible behaviors. Focusing on behaviors rather than attributes may facilitate discussion, assessment, and modeling of professionalism in both medical education and clinical care.

Hochberg MS, Kalet A, Zabar S, et al: Can professionalism be taught? Encouraging evidence. *The American Journal of Surgery*. 2010;199:86-93.

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

Over the past twenty-five years, professionalism has emerged as a substantive and sustained theme, the operationalization and measurement of which, has become a major concern for those involved in medical education. However, how to go about establishing the elements that constitute appropriate professionalism in order to assess them is difficult. Using a discourse analysis approach, the International Ottawa

Conference Working Group on Professionalism (IOCPWG) studied some of the dominant notions of professionalism, and in particular the implications for its assessment. The results presented here reveal different ways of thinking about professionalism that can lead toward a multi-dimensional, multi-paradigmatic approach to assessing professionalism at different levels: individual, inter-personal, societal-institutional. Recommendations for research about professionalism assessment are also presented.

*Holden MD, Buck E, Luk J, et al: Professional identity formation: creating a longitudinal framework through TIME (Transformation in Medical Education). *Academic Medicine*. 2015;90(6):761-767.

The University of Texas System established the Transformation in Medical Education (TIME) initiative to reconfigure and shorten medical education from college matriculation through medical school graduation. One of the key changes proposed as part of the TIME initiative was to begin emphasizing professional identity formation (PIF) at the premedical level. The TIME Steering Committee appointed an interdisciplinary task force to explore the fundamentals of PIF and to formulate strategies that would help students develop their professional identity as they transform into physicians. In this article, the authors describe the task force's process for defining PIF and developing a framework, which includes 10 key aspects, 6 domains, and 30 subdomains to characterize the complexity of physician identity. The task force mapped this framework onto three developmental phases of medical education typified by the undergraduate student, the clerkship-level medical student, and the graduating medical student. The task force provided strategies for the promotion and assessment of PIF for each subdomain at each of the three phases, in addition to references and resources. Assessments were suggested for student feedback, curriculum evaluation, and theoretical development. The authors emphasize the importance of longitudinal, formative assessment using a combination of existing assessment methods. Though not unique to the medical profession, PIF is critical to the practice of exemplary medicine and the well-being of patients and physicians.

*Irby DM, Hamstra SJ: Parting the clouds: three professionalism frameworks in medical education. *Academic Medicine*. 2016;91:1606-1611.

Current controversies in medical education associated with professionalism, including disagreements about curriculum, pedagogy, and assessment, are rooted in part in the differing frameworks that are used to address professionalism. Three dominant frameworks, which have evolved in the medical education community, are described. The oldest framework is virtue based and focuses on the inner habits of the heart, the development of moral character and reasoning, plus humanistic qualities of caring and compassion: The good physician is a person of character. The second framework is behavior based, which emphasizes milestones, competencies, and measurement of observable behaviors: The good physician is a person who consistently demonstrates competence in performing patient care tasks. The third framework is identity formation, with a focus on identity development and socialization into a community of practice: The good physician integrates into his or her identity a set of values and dispositions consonant with the physician community and aspires to a professional identity reflected in the very best physicians. Although each professionalism framework is useful and valid, the field of medical education is currently engaged in several different discourses resulting in misunderstanding and differing

recommendations for strategies to facilitate professionalism. In this article, the assumptions and contributions of each framework are described to provide greater insight into the nature of professionalism. By examining each discourse in detail, underlying commonalities and differences can be highlighted to assist educators in more effectively creating professionalism curricula, pedagogy, and assessment.

Jarvis-Selinger S, Pratt DD, Regehr G: **Competency is not enough: Integrating identity formation into the medical education discourse**. *Academic Medicine*. 2012;87(9):1185-1190.

Despite the widespread implementation of competency-based medical education, there are growing concerns that generally focus on the translation of physician roles into "measurable competencies." By breaking medical training into small, discrete, measurable tasks, it is argued, the medical education community may have emphasized too heavily questions of assessment, thereby missing the underlying meaning and interconnectedness of how physician roles shape future physicians. To address these concerns, the authors argue that an expanded approach be taken that includes a focus on professional identity development. The authors provide a conceptual analysis of the issues and language related to a broader focus on understanding the relationship between the development of competency and the formation of identities during medical training. Including identity alongside competency allows a reframing of approaches to medical education away from an exclusive focus on "doing the work of a physician" toward a broader focus that also includes "being a physician." The authors consider the salient literature on identity that can inform this expanded perspective about medical education and training.

*Kalet A, Guerrasio J, Chou CL: **Twelve tips for developing and maintaining a remediation program in medical education.** *Medical Teacher*. Published online 06 April 2016.

Remediation in medical education, the process of facilitating corrections for physician trainees who are not on course to competence, predictably consumes significant institutional resources. Although remediation is a logical consequence of mandating, measuring, and reporting clinical competence, many program leaders continue to take an unstructured approach toward organizing effective, efficient plans for struggling trainees, almost all of who will become practicing physicians. The following 12 tips derive from a decade of remediation experience at each of the authors' three institutions. It is informed by the input of a group of 34 interdisciplinary North American experts assembled to contribute two books on the subject. We intend this summary to guide program leaders to build better remediation systems and emphasize that developing such systems is an important step toward enabling the transition from time-based to competency-based medical education.

Kalet A, Buckvar-Keltz L, Harnik V, et al: **Measuring professional identity formation early in medical school.** *Medical Teacher*. 2017; 39(3):255-261.

ABSTRACT
Aim: To assess the feasibility and utility of measuring baseline professional identity formation (PIF) in a theory-based professionalism curriculum for early medical students.
Methods: All 132 entering students completed the professional identity essay (PIE) and the defining issues test (DIT2). Students received score reports with individualized

narrative feedback and wrote a structured reflection after a large-group session in which the PIF construct was reviewed. Analysis of PIEs resulted in assignment of a full or transitional PIF stage (1–5). The DIT2 score reflects the proportion of the time students used universal ethical principles to justify a response to 6 moral dilemma cases. Students' reflections were content analyzed.

Results: PIF scores were distributed across stage 2/3, stage 3, stage 3/4, and stage 4. No student scores were in stages 1, 2, 4/5, or 5. The mean DIT2 score was 53% (range 9.7–76.5%); the correlation between PIF stage and DIT score was q 1/4 0.18 (p 1/4 0.03). Students who took an analytic approach to the data and demonstrated both awareness that they are novices and anticipation of continued PIF tended to respond more positively to the feedback.

Conclusions: These PIF scores distributed similarly to novice students in other professions. Developmental theory based PIF and moral reasoning measures are related. Students reflected on these measures in meaningful ways suggesting utility of measuring PIF scores in medical education.

Larkin GL, Binder L, Houry D, Adams J: **Defining and evaluating professionalism: a core competency for graduate emergency medicine education**. *Academic Emergency Medicine*. 2002;9(11):1249-1256.

Professionalism, long a consideration for physicians and their patients, is coming to the forefront as an essential element of graduate medical education as one of the six new core competency requirements of the Accreditation Council for Graduate Medical Education (ACGME). Professionalism is also integral to the widely endorsed Model of the Clinical Practice of Emergency Medicine (Model). Program directors have now been charged with implementing the new core competencies in training programs and to assess the acquisition of these competencies in their trainees. To assist emergency medicine (EM) program directors in this endeavor, the Council of Emergency Medicine Residency Directors (CORD-EM) held a consensus conference in March 2002. A focused Consensus Group addressed the specific core competency of professionalism during the course of this conference, and the results are highlighted in this article. The definition and curricular requirements relating to professionalism are highlighted, specific techniques for evaluating this core competency in EM are reviewed, and recommendations are provided regarding the most appropriate assessment method for EM programs.

Lesser CS, Lucey CR, Egener B: **A behavioral and systems view of professionalism.** *JAMA*. 2010;304:2732-2737.

Professionalism may not be sufficient to drive the profound and far reaching changes needed in the US health care system, but without it, the health care enterprise is lost. Formal statements defining professionalism have been abstract and principle based, without a clear description of what professional behaviors look like in practice. This article proposes a behavioral and systems view of professionalism that provides a practical approach for physicians and the organizations in which they work. A more behaviorally oriented definition makes the pursuit of professionalism in daily practice more accessible and attainable. Professionalism needs to evolve from being conceptualized as an innate character trait or virtue to sophisticated competencies that can and must be taught and refined over a lifetime of practice. Furthermore, professional behaviors are profoundly influenced by the organizational and environmental context of contemporary medical practice, and these external forces

need to be harnessed to support—not inhibit—professionalism in practice. This perspective on professionalism provides an opportunity to improve the delivery of health care through education and system-level reform.

Lucey C, Souba W: **The problem with the problem of professionalism**. *Academic Medicine*. 2010;85:1018-1024.

Enhancing professionalism is an important goal of all physicians, both as individuals and as members of educational and institutional communities of practice. Despite a great deal of dialogue and discourse, the medical profession struggles to ensure that all physicians are able to embrace and live the values of professionalism, notwithstanding the myriad stressors present in today's evolving health care environment. The authors suggest a move beyond the traditional educational paradigms focused on reinforcing rules, providing role models, rewarding right behavior, and removing those who falter, and that we instead view the problem of professionalism as a complex adaptive challenge requiring new learning. Approaching lapses in professionalism as a form of medical error may provide a fresh outlook and may lead to the development of successful strategies to help physicians realize their commitment to the values of professionalism, despite the inevitable challenges that arise throughout their careers.

Oates M: **Socio-material theory: an alternative view of interprofessional team learning**. Medical Education. 2016;50:160-166.

It is highly likely that we have encountered a health professional who strikes us as having excellent clinical judgement, academic knowledge and technical skills, but with a style one could only describe as 'does not play well with others'. Is the ability to work effectively as part of a team an essential competency for health professionals? If so, is it something that can be taught as part of pre-qualification training and measured in a reproducible and standardised way? To advance our understanding of interprofessional education and team-based learning, a range of theoretical perspectives must be considered. In this issue, McMurtry and colleagues use the emerging field of sociomaterial theory to explore the nature of learning as it occurs in interprofessional teams. It is from the point of view of an educator interested specifically in pre-qualification interprofessional education that I offer this commentary.

Quaintance JL Arnold L, Thompson GS: **What students learn about professionalism from faculty stories: an "appreciative inquiry" approach**. *Academic Medicine.* 2010;85:118-123.

Purpose: To develop a method for teaching professionalism by enabling students and faculty members to share positive examples of professionalism in a comfortable environment that reflects the authentic experiences of physicians. Medical educators struggle with the teaching of professionalism. Professionalism definitions can guide what they teach, but they must also consider how they teach it, and constructs such as explicit role modeling, situated learning, and appreciative inquiry provide appropriate models.
Method: The project consisted of students interviewing faculty members about their experiences with professionalism and then reflecting on and writing about the teachers' stories. In 2004, 62 students interviewed 33 faculty members, and 193 students observed the interviews. Using a project Web site, 36 students wrote 132 narratives based on the faculty's stories, and each student offered his or her reflections on one

narrative. The authors analyzed the content of the narratives and reflections via an iterative process of independent coding and discussion to resolve disagreements.
Results: Results showed that the narratives were rich and generally positive; they illustrated a broad range of the principles contained in many definitions of professionalism: humanism, accountability, altruism, and excellence. The students' reflections demonstrated awareness of the same major principles of professionalism that the faculty conveyed. The reflections served to spark new ideas about professionalism, reinforce the values of professionalism, deepen students' relationships with the faculty, and heighten students' commitment to behaving professionally.
Conclusions: Narrative storytelling, as a variant of appreciative inquiry, seems to be effective in deepening students' understanding and appreciation of professionalism.

Roberts C, Wilkinson TJ, Norcini J, Patterson F, Hodges BD: **The intersection of assessment, selection and professionalism in the service of patient care.** *Medical Teacher*. 2019;41(3):243-248.

The addition of a consensus statement on the assessment of professionalism (Hodges et al. 2018) in this edition of the journal complements the two statements published in an earlier issue: one on Assessment (Norcini et al. 2018) and the other on Selection and Recruitment (Patterson et al. 2018). The ways in which these three statements might intersect and bring new understandings about the relationships among professionalism, assessment, and selection were raised at the 2018 Ottawa-ICME Joint Conference on the Assessment of Competence in Medicine and the Healthcare Professions. In recognition of the lack of guiding literature, a compelling case emerged during the conference to further consider the ways in which the professionalism of health education students and graduates can be re-conceptualized within systems of selection and assessment. In this paper, we begin that conversation so that it might provide fruitful insights and stimulate future debate from a practice, theoretical, and research basis. Our guiding question was "What is the relationship between professionalism as a construct and systems of assessment and selection?" We begin by summarizing some of the key features recommended by the international working group on assessment in professionalism, and the ways in which their three levels of assessment resonate with the consen- sus statements in assessment and selection. We draw out what is common to all three statements, what is different, and the ways in which new understandings might lead to changes in selection and assessment systems, and further sharpen the ways in which the assessment of professional- ism is considered.

* Steinert Y, Cruess S, Cruess R, Snell L: **Faculty development for teaching and evaluating professionalism: from programme design to curriculum change**. *Medical Education.* 2005;39:127-136.

Introduction: The recent emphasis on the teaching and evaluation of professionalism for medical students and residents has placed significant demands on medicine's educational institutions. The traditional method of transmitting professional values by role modelling is no longer adequate, and professionalism must be taught explicitly and evaluated effectively. However, many faculty members do not possess the requisite knowledge and skills to teach this content area and faculty development is therefore required.

Programme Description: A systematic, integrated faculty development programme was designed to support the teaching and evaluation of professionalism at our institution. The programme consisted of think tanks to promote consensus and 'buy-in', and workshops to convey core content, examine teaching strategies and evaluation methods, and promote reflection and self-awareness.

Programme Evaluation: The programme was evaluated using a CIPP (**c**ontext, **i**nput, **p**rocess, **p**roduct) analysis. The institution supported this initiative and local expertise was available. A total of 152 faculty members, with key educational responsibilities, attended 1 or more faculty development activities. Faculty participation resulted in agreement on the cognitive base and attributes of professionalism, consensus on the importance of teaching and evaluating professionalism, and self-reported changes in teaching practices. This initiative also led to the development of new methods of evaluation, site-specific activities and curriculum change.

Discussion: A faculty development programme designed to support the teaching and evaluation of professionalism can lead to self-reported changes in teaching and practice as well as new educational initiatives. It can also help to develop more knowledgeable faculty members, who will, it is hoped, become more effective role models.

Suchman AL, Williamson PR, Litzelman DK, et al: **Toward an informal curriculum that teaches professionalism – Transforming the social environment of a medical school.** *Journal of General Internal Medicine*. 2004;19:501-504.

The social environment or "informal" curriculum of a medical school profoundly influences students' values and professional identities. The Indiana University School of Medicine is seeking to foster a social environment that consistently embodies and reinforces the values of its formal competency-based curriculum. Using an appreciative narrative-based approach, we have been encouraging students, residents, and faculty to be more mindful of relationship dynamics throughout the school. As participants discover how much relational capacity already exists and how widespread is the desire for a more collaborative environment, their perceptions of the school seem to shift, evoking behavior change and hopeful expectations for the future.

Wilkinson TJ, Wade WB: **A blueprint to assess professionalism: Results of a systematic review**. *Academic Medicine*. 2009;84:551-558.

Purpose: Assessing professionalism is hampered by varying definitions and these definitions' lack of a clear breakdown of the elements of professionalism into aspects that can be measured. Professionalism is multidimensional, so a combination of assessment tools is required. In this study, conducted during 2007–2008, the authors aimed to match assessment tools to definable elements of professionalism and to identify gaps where professionalism elements are not well addressed by existing assessment tools.

Method: The authors conducted literature reviews of definitions of professionalism and of relevant assessment tools, clustered the definitions of professionalism into assessable components, and clustered assessment tools of a similar nature. They then created a "blueprint" whereby the elements of professionalism are matched to relevant assessment tools.

Results: Five clusters of professionalism were formed: adherence to ethical practice principles, effective interactions with patients and with people who are important to those patients, effective interactions with people working within the health system,

reliability, and commitment to autonomous maintenance / improvement of competence in oneself, others, and systems. Nine clusters of assessment tools were identified: observed clinical encounters, collated views of coworkers, records of incidents of unprofessionalism, critical incident reports, simulations, paper-based tests, patients' opinions, global views of supervisor, and self-administered rating scales.
Conclusions: Professionalism can be assessed using a combination of observed clinical encounters, multisource feedback, patients' opinions, paper-based tests or simulations, measures of research and/or teaching activities, and scrutiny of self-assessments compared with assessments by others. Attributes that require more development in their measurement are reflectiveness, advocacy, lifelong learning, dealing with uncertainty, balancing availability to others with care for oneself, and seeking and responding to results of an audit.

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