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COMMENTARY

Teaching professionalism: general principles

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ABSTRACT *There are educational principles that apply to the teaching of professionalism during undergraduate education and postgraduate training. It is axiomatic that there is a single cognitive base that applies with increasing moral force as students enter medical school, progress to residency or registrar training, and enter practice. While parts of this body of knowledge are easier to teach and learn at different stages of an individual's career, it remains a definable whole at all times and should be taught as such. While the principle that self-reflection on theoretical and real issues encountered in the life of a student, resident or practitioner is essential to the acquisition of experiential learning and the incorporation of the values and behaviors of the professional, the opportunities to provide situations where this can take place will change as an individual progresses through the system, as will the sophistication of the level of learning. Teaching the cognitive base of professionalism and providing opportunities for the internalization of its values and behaviors are the cornerstones of the organization of the teaching of professionalism at all levels. Situated learning theory appears to provide practical guidance as to how this may be implemented. While the application of this theory will vary with the type of curriculum, the institutional culture and the resources available, the principles outlined should remain constant.*

Introduction

Recently there have been calls for improved teaching of professionalism to medical students, residents and during continuing professional development (Cruess & Cruess, 1997b; General Medical Council, 2001; Inui, 2003; Royal College of Physicians of London, 2005). These calls arise from public dissatisfaction with the performance of the medical profession in areas where they have direct responsibility—such as self-regulation—as well as the public's perception that members of the profession are less altruistic than in previous times (Starr, 1984; Stevens, 2001). There have also been calls for reform of medical education in order to improve the health of the public (Solyom, 2005). From the point of view of the medical profession the entry of the state and the corporate sector into the medical marketplace have significantly changed the social contract, leading to a belief that the traditional values of the profession are under threat and hence must be actively taught and promoted (Cruess & Cruess, 1997b; Irvine, 1997a, 1997b; ABIM, 2002; Royal College of Physicians of London, 2005). Professionalism was traditionally transmitted using respected role models. This method depended for its success on the presence of shared values in a relatively homogeneous medical profession serving a similarly homogeneous society, a situation that no longer exists in our wonderfully diverse world. Thus role modeling, which remains an immensely powerful tool (Wright *et al.*, 1998; Wright & Carrese, 2001; Kenny *et al.*, 2003), is no longer sufficient. It is now felt that professionalism must also be taught explicitly. The past decade has seen the development of new approaches to the teaching of professionalism and there is agreement on many areas.

Educational theory

Maudsley & Strivens (2004) have proposed that, of the educational theories available, 'situated learning' theory seems to describe the most effective model to assist in the design of programs which have as their objective the transformation of students from members of the lay public (or non-experts) to expert members of a profession, with both appropriate skills and a commitment to a common set of values. It suggests that learning should be embedded in authentic activities which help to transform knowledge from the abstract and theoretical to the usable and useful. Its proponents believe that there should be a balance between explicit teaching of a subject and activities in which the knowledge learned is used in an authentic context (Brown *et al.*, 1989). While the theory is applicable to all forms of learning, it seems particularly appropriate to educating for the professions, which are communities or cultures joined by ''intricate, socially constructed webs of belief'' (Brown *et al.*, 1989, p. 33). An individual's desire to learn is engaged and can be linked to the intention to join the community of medical professionals.

One contemporary school of thought has emphasized that professionalism needs to be taught explicitly, utilizing either definitions or outlining professionalism as a list of traits or characteristics (Cruess & Cruess, 1997a, 1997b; Swick, 2000; ABIM, 2003). The objective is to ensure that every physician understands the nature of professionalism, its basis in morality, the reasons for its existence, its characteristics, and the obligations necessary to sustain it. This can be termed the cognitive base of professionalism: in terms of the theory, the subject to be learned is first articulated.

Others have stated that the teaching of professionalism should be approached primarily as a moral endeavor, emphasizing altruism and service, stressing the importance

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of role modeling, efforts to promote self-awareness, community service, and other methods of acquiring experiential knowledge (Coulehan, 2005; Huddle, 2005). Explicit teaching receives less attention. They seek to embed the learning in an authentic activity, emphasizing the usefulness of the knowledge.

While it would be wrong to overemphasize the differences between these two approaches, they do exist. In this instance, everyone appears to be correct (Fox, 1989; Ludmerer, 1999). Professionalism *must* be taught explicitly as physicians have demonstrated by their well-documented failures that they do not fully understand the obligations associated with contemporary professionalism (Cruess & Cruess, 1997a; Irvine 1997a, 1997b). If physicians as rational human beings are to incorporate a set of values into their day-to-day life, they must be able to articulate them, along with the reasons for their existence. However, when the teaching of professionalism is limited to one or more formal didactic sessions outlining the cognitive base, the impact will be minimal. Professionalism is fundamental to the process of socialization during which individuals acquire the values, attitudes, interests, skills and knowledge—the culture—of the groups of which they seek to become a member (Fox, 1989; Hafferty, 2003). As situated learning theory suggests, a balance must be struck between teaching the cognitive base explicitly and providing opportunities where learning can occur in an authentic context (Brown *et al.*, 1989; Ludmerer, 1999; Maudsley & Strivens, 2004).

Principles

Teaching the cognitive base of professionalism is not difficult. Establishing an environment where the process of socialization in its most positive sense can take place is much harder. How this is best accomplished constitutes the main challenge to medical educators at the present time. There are several important factors to be considered.

Institutional support

Establishing a major program of instruction requires the support of those directing medical schools and hospitals (Hafferty, 2003; Inui, 2003). The active participation of Deans, department chairs and program directors is required to send a message that the subject is important. Their support must be manifested by decisions taken—the allocation of space, teaching time and financial resources (Hafferty & Franks, 1994; Hafferty, 1995; Inui, 2003). As well, the institution's reward system must recognize those who participate.

The cognitive base

Students and residents must understand the nature of professionalism, its historical roots, the reasons society uses the professions, the obligations necessary to sustain professional status, and its relationship to medicine's social contract with society (Cruess & Cruess, 1997a; Sullivan, 2005). The definition and description of professionalism are of paramount importance as they dictate what will be taught, evaluated and expected of students, trainees and physicians. Therefore each institution must agree on the substance of the cognitive base and this must remain consistent throughout the educational process. There is now a rich literature available to physicians on the subject (Swick, 2000; ABIM, 2002; Inui, 2003; Cruess *et al.*, 2004; Royal College of Physicians of London, 2005). A variety of educational techniques can be used, but professionalism must be taught explicitly, and the point made that professional status is a privilege granted by society that can be changed if society wishes.

Experiential learning

Professional identity arises ''from a long term combination of experience and reflection on experience'' (Hilton & Slotnick, 2005, p. 63). A major objective of medical education should be to provide stage-appropriate opportunities for gaining experience and reflecting on it (Dreyfus & Dreyfus, 1980; Leach, 2002). There must be structured opportunities that allow students, residents and, indeed, practitioners to discuss professional issues in a safe environment, personalize them and, it is hoped, internalize them over the course of education and training (Wear & Castellani, 2002; Inui, 2003; Maudsley & Strivens, 2004; Benbassat & Baumal, 2005). In this way they develop their professional identity over a period of time, changing from novices into skilled professionals. The insight gained becomes part of a larger body of knowledge described as tacit: that which one knows but cannot tell (Polanyi, 1958). While tacit knowledge is difficult to teach, it can be learned (Schon, 1987). It is best learned not in the lecture hall, but by situated learning which encourages self-reflection and promotes 'mindfulness' (Epstein, 1999) or 'reflective practice' (Schon, 1983).

Continuity

It has also become evident that professionalism must be taught throughout the curriculum at both the undergraduate and postgraduate levels (Rudy *et al.*, 2001; Wear & Castellani, 2002; Inui, 2003). As the objective is both to teach the cognitive base and to internalize the values of the profession, instruction and opportunities for self-reflection appropriate to the stage of training must be provided in all major teaching units. In this way the growth of both explicit and tacit knowledge of professionalism will take place in parallel with growth of knowledge in other areas. Professionalism must be a part of all of medicine and taught in an integrated fashion throughout the curriculum.

Role modeling

Role models remain the most potent means of transmitting those intangibles that have been called the art of medicine (Wright *et al.*, 1998; Wright & Carrese, 2001; Hafferty, 2003; Kenny *et al.*, 2003; Huddle, 2005). They are also important in the development of the sense of collegiality, which serves to obtain agreement on the common goals of the profession and encourage compliance with them (Ihara, 1988). The peer pressure of respected role models remains an enormously powerful tool (Schon, 1987). Conversely, the destructive effects of role models who fail to meet acceptable professional standards can be equally strong (Feudtner *et al.*, 1994). Negative role modeling is pervasive and must be addressed

by improving the performance of those who do not meet acceptable standards or removing them from contact with students or residents.

Faculty development

For role models to be effective they must understand the role that they are modeling. This starts with faculty agreement on definitions consistent with the literature on the subject of professionalism and its characteristics, as well as on standards of behavior. To achieve consensus and ensure that faculty have the necessary knowledge and skills to both teach and role model professionalism, faculty development is essential (Hafferty, 1995; Steinert *et al.*, 2005). The role must be made explicit to the role model as well as the student.

Evaluation

What has been learned (as opposed to what has been taught) must be assessed as evaluation drives learning (Stern, 2005). Students need to know if they are meeting professional expectations. Formative evaluations with feedback on a regular basis are essential tools to assist students and residents in achieving their goals.

Professionalism is so fundamental to medicine's relationship to society that evidence that its cognitive base has been learned and its values internalized and reflected by behaviors must be recorded (Irvine, 1997a, 1997b; ABIM, 2003; Royal College of Physicians of London, 2005). The public must be assured of the competence and character of graduates of both undergraduate and postgraduate programs. Medicine as a profession is granted the privilege of self-regulation, which requires that it set and maintain standards (Cruess & Cruess, 1997; Irvine, 1997a, 1997b; Stevens, 2001; Sullivan, 2005). Regular and rigorous evaluation is essential to meet this obligation, with summative evaluation providing evidence of the profession's accountability in this domain. This issue has been given added urgency by studies indicating that lapses in professional behavior observed in medical school are associated with subsequent unprofessional conduct in practice (Kirk & Blank, 2005; Papadakis *et al.*, 2005).

The environment

The institutional culture either can support professional behavior or subvert it. Medical education is carried out in an environment that is heavily influenced by many forces within medicine's institutions and in the healthcare system (Hafferty, 2003; Inui, 2003). There is a 'formal curriculum' that is outlined in the mission statement of the institution and its course objectives (Hafferty & Franks, 1994; Hafferty, 1995). This states what the faculty believe that they are teaching. There is also an extremely powerful 'informal curriculum' consisting of unscripted, unplanned and highly interpersonal forms of teaching and learning that take place among and between faculty and students. Role models at several levels, from peers to senior physicians, participate at this level and can have a profound effect for good or ill on the attitudes of students and residents. In addition, there is a set of influences which is largely hidden that function at the level of the organizational structure and culture. The influence of this 'hidden curriculum' on professional values can, like role models, be either extremely positive or very negative. Decisions that favor research or profit over teaching or ignore patient or community needs send a message which is difficult to counteract. The informal and hidden curricula are partly responsible for the difference between what students are taught and what they actually learn (Hafferty, 2003). A broadly based faculty development program can help to change the environment and affect the informal curriculum (Steinert *et al.*, 2005). However, the hidden curriculum also requires attention (Hafferty, 1995; Inui, 2003; Suchman *et al.*, 2004). The incentives and disincentives built into any institutional culture may require changes, along with other factors including economic and structural policies established at the institutional level.

In summary, the teaching of professionalism should start with the recognition that there is a cognitive base to professionalism which must be taught explicitly and then be reinforced and internalized by the student through experiential learning. This requires a strong institutional commitment to supporting the teaching program throughout the educational process. The issue is of importance to both medicine and society, as ''medical professionalism lies at the heart of being a good doctor'' (Royal College of Physicians of London, 2005).

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