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TWELVE TIPS

Twelve Tips for teaching medical professionalism at all levels of medical education

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Abstract

Review of studies published in medical education journals over the last decade reveals that teaching medical professionalism is essential, yet challenging. According to a recent Best Evidence in Medical Education (BEME) guide, there is no consensus on a theoretical or practical model to integrate the teaching of professionalism into medical education. The aim of this article is to outline a practical manual for teaching professionalism at all levels of medical education. Drawing from research literature and author's experience, Twelve Tips are listed and organised in four clusters with relevance to (1) the context, (2) the teachers, (3) the curriculum, and (4) the networking. With a better understanding of the guiding educational principles for teaching medical professionalism, medical educators will be able to teach one of the most challenging constructs in medical education.

Introduction

> *Professionalism must be taught.*
> (Cruess & Cruess 1997, p. 1674)
> *It is never easy teaching professionalism.*
> (Beauchamp 2004, p. 699)

These two quotes imply the necessity and intricacy of teaching professionalism. Professionalism exemplifies the expected behaviours and attributes towards which physicians – and other health professionals – aspire while serving their patients and society (Cruess et al. 2002).

For decades, professional values and behaviours have been *caught* from role-models through an informal process of socialisation (Loh & Nalliah 2010), but role modelling – alone – is no longer enough for transmitting professional values in view of the emerging complexity of medical practice and the heterogeneity of medical students who enter the study of medicine from diverse social, cultural and socioeconomic backgrounds (Cruess & Cruess 2006). The disciplinary action by regulatory bodies was strongly associated with prior unprofessional behaviour in medical school (Papadakis et al. 2004). Now a better informed community is asking for accountability, transparency and sound professional standards to meet their expectations (Cruess et al. 2000). Professionalism, therefore, must be planned, taught, learned and assessed explicitly (Cruess & Cruess 1997; Sivalingam & Mal 2004).

Two schools of thoughts guide the teaching and learning of professionalism, either by outlining a list values and desirable professional behaviours (Cruess et al. 2009) or as a normative belief system about how best to organise and deliver healthcare (Wynia et al. 2014). The two schools are complementary to each other as they engage, not only the *minds*, but also the *hearts* and *souls* of professionals (Wood 2004).

Professionalism remains one of the most challenging competencies to define, teach and evaluate, because of the complex and context-specific nature of professionalism as a competence (Swick 2000; Bryden et al. 2010; Hafferty & Castellani 2010). Considering that the modern professionalism debate has been going on for the past two decades, it is surprising that the literature does not contain clear practical examples of how professionalism can be taught (Birden et al. 2013). This article proposes 12 practical tips to empower faculty members to teach professionalism, with reference to relevant theoretical background. The tips are organised into four clusters with relevance to (1) the context, (2) the teachers, (3) the curriculum, and (4) the networking, as illustrated in Figure 1.

Tip 1

Determine the cultural context

Medical professionalism is a complex social construct and the context, geographical location and culture are important considerations in any discussion of professional behaviour (Jha et al. 2014). There may be some regional similarities and variances in understandings of professionalism, most of which can be explained by cultural differences (Chandratilake et al. 2012), but there is no overarching conceptual context of medical professionalism that is universally agreed upon (Ho et al. 2011).

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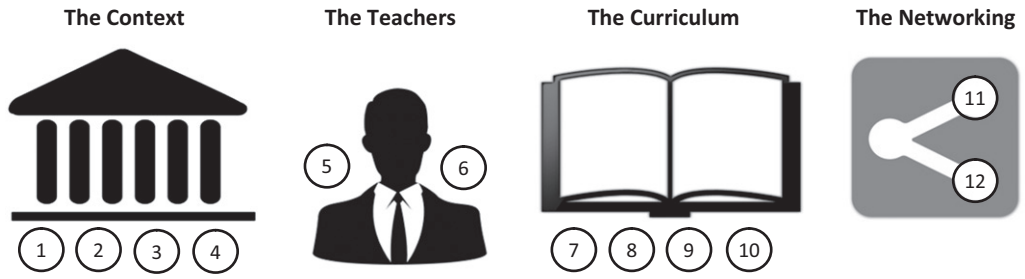

Figure 1. The twelve tips for teaching medical professionalism at all levels of medical education, as grouped in four clusters.

The professionalism framework of the American Board of Internal Medicine (ABIM) includes six domains, namely: altruism, accountability, excellence, duty, honour and integrity, and respect for others (ABIM 1995). The Western frameworks of medical professionalism, however, did not resonate with the cultural values of non-Western countries (Pan et al. 2013). For instance, while Western frameworks dichotomised physicians' professional and personal lives, Taiwanese stakeholders were influenced by Confucian cultural traditions toward harmonising these roles (Ho et al. 2011). The evident cultural variations and context specificity of professionalism stimulates scholarly efforts to develop more authentic frameworks to represent professionalism in non-western cultures.

Pan et al. (2013) proposed a professionalism framework for healthcare providers in China, using a nominal group technique, that registered particular Confucian attributes like "*ren ai*" or humane love and "*gong xin*" or public spiritedness. Also, Nishigori et al. (2014) compared the tenets of professionalism in the American context with the seven virtues of *Bushido*, a Japanese code of personal conduct originating from the ancient samurai warriors. In the same vein, another framework was also reported for Arabian health providers, named the Four-Gates model, which portrays four levels (gates) of accountability while (1) dealing with self, (2) dealing with task, (3) dealing with others and (4) dealing with God (Al-Eraky et al. 2014). The fourth gate (dealing with God) interprets self-accountability and self-motivation from a faithful perspective as "*taqwa*" and "*ehtesab*", respectively, in Arabic, which recognises faith as a cornerstone in communication and social values in the Arabian context (Al-Eraky et al. 2014). The first tip is about recognising or building a framework that encompasses the salient domains of professionalism in your own context.

Tip 2

Outline the cognitive base

Each institution should agree on the "*cognitive base*" of professionalism that defines its nature, elements and priorities, which dictates what will be taught, evaluated and expected of students, trainees and physicians (Cruess & Cruess 2006). The cognitive base is the basis of the *social contract* (Welie 2012) which acknowledges the series of expectations and obligations between society and medicine, and it manifests the *social accountability* of the institution to address the essential professional concerns of the community, region and/or nation they serve (Woollard 2006; Boelen & Woollard 2011). Understanding professionalism in a particular institution is influenced by variables related to its vision, scope of services, ownership (public or private), priorities and future plans. Within the same institution or university, colleges and departments may prioritise professional attributes differently. For instance, more emphasis can be given to empathy in nursing, humility in surgery, excellence in laboratory medicine, accountability in pharmacy and confidentiality in psychiatry. Teaching the cognitive base of professionalism is not difficult (Cruess & Cruess 2006). Gaining the institutional support and establishing an environment, where the process of socialisation in its most positive sense can take place, is much harder.

Tip 3

Seek institutional support

Professionalism education is primarily an institutional responsibility (Goldstein et al. 2006). You have to advocate the value of teaching professionalism to educational leaders, colleagues, faculty members and students. Establishing *a sense of urgency* is crucial to seek support from leadership to teach professionalism (Steinert et al. 2005). This can be done by notifying the leadership by the current erosions in ethical obligations, medical errors, professional lapses (Ainsworth & Szauter 2006) and sometimes reports of medical litigations and law suits (Marei 2013) to advocate the mounting importance of teaching professionalism at all levels of medical education. The engagement of the deans, department chairs and programme directors sends a clear message of the significance of professionalism education (Cruess & Cruess 2006). The institutional support must be manifested by "*decisions*" to allocate appropriate recourses, "*rewards*" for those who participate in teaching professionalism and "*policies*" to promote a professional environment (Suchman et al. 2004).

Tip 4

Promote professional environment

Professionalism cannot be taught and learned in a vacuum. The institutional culture can either support professional behaviour or subvert it. Students learn aspects of professionalism as integrated in the *stated* curriculum (O'Sullivan et al.

2012) and also as they explore it in the *hidden* one (Glicken & Merenstein 2007; Al-Abdulrazzaq et al. 2014; MacLeod 2014). The hidden curriculum represents the actions of faculty members that are observed by medical students throughout the course.

The institutional support – gained in Tip 3 – can be invested to direct administrators, medical educators, residents and students to address the hidden curriculum openly and proactively. A top–down approach may not be enough to promote an environment that fosters professionalism. Roff & Dherwani (2011) advocated a bottom–up approach where junior trainees and (even) medical students should be vigilant and responsive to professional lapses in educational and clinical practice. They should learn when they may ignore, challenge the individual, discuss with peers or report the lapse to a more senior person, if their teachers exhibit certain behaviours. This approach fosters a culture of "*local resolution*" in which juniors feel empowered to address poor professionalism and guide undergraduate fitness to practice procedures (Roff & Dherwani 2011).

Tip 5

Foster role-modelling

> *The most important, indeed the only, thing we have to offer our students is ourselves. Everything else they can read in a book.* (Tosteson 1979)

We – faculty – should keep in mind that we are being judged by students and colleagues all the time (Finn et al. 2010). Almost 90% of the medical graduates remember role models who shaped their professional attitudes (Wright et al. 1997). Role-modelling is a powerful (Cruess et al. 2008), yet underexploited teaching strategy (Kenny et al. 2003). The characteristics of role models can be categorised into three clusters related to: clinical competence, teaching skills and personal qualities (Cruess et al. 2008). Virtuous role models who actually "*walk their talk*" are invaluable for transmitting the intangible elements of professionalism (Finn et al. 2010). Students identify the need for strong *positive* role models in their learning environment (Byszewski et al. 2012). Also, the *negative* role-modelling is a major potential obstacle for developing professional behaviours among medical students (Adkoli et al. 2011).

The educational value of role-modelling can be enhanced via two complementary approaches. Firstly, the institution should communicate pre-set criteria for excellence in education and clinical practice and then reward those who are acknowledged by students, patients and peers as exemplary models. On the other hand, unprofessional behaviours should be clearly labelled and categorised. Policies and procedures for reporting and remediation have to be communicated to students and health professionals (Smith et al. 2007). Secondly, students and residents should learn how to be reflective and selective to filter and emulate only positive behaviours that are worth imitation and modelling (Benbassat 2014).

Tip 6

Train faculty members to teach professionalism

Professionalism is one of the most challenging competencies to define, teach and evaluate for faculty members (Joyner & Vemulakonda 2007; Bryden et al. 2010). Also, those who are supposed to teach professionalism actually receive minimal attention as evidenced by the limited number of researches studying professionalism in the context of faculty development (Steinert et al. 2005; Steinert et al. 2007; Lu et al. 2014; Al-Eraky et al., 2015). Faculty development programmes can be designed not only to empower faculty members with teaching tools to address professionalism in their courses, but it can also supplement professionalism education in different dimensions. Specialised workshops or longitudinal programmes can be planned for a number of objectives: to conceptualise the cultural framework of professionalism in a particular context (Tip 1), to help in defining the cognitive base on professionalism on the institutional level (Tip 2), to seek institutional support and validate the leadership's commitment to professionalism education to all stakeholders (Tip 3), to communicate un/professional behaviours and policies governing performance in education and clinical practice to promote professional environment (Tip 4), to develop more knowledgeable faculty members, who will, hopefully, become more effective role models (Tip 5), and finally to bring about curricular changes to set clear expectations on professionalism across the continuum of medical education (Tip 7).

Tip 7

Define expectations as observable behaviours

Generally it is difficult to observe and measure values. In addition, the use of value terms in giving feedback to students, residents and colleagues can be very threatening, because it implies character defects. In contrast, behaviours can be observed and measured and it is less threatening to tell someone that he or she lapsed from the desirable behaviour in a particular situation (Kirk 2007). The learning outcomes of professionalism have to be operationalised in tangible behaviours, rather than a set of abstract attributes and values (Hafferty 2004; Blue et al. 2009). Defining expectations as observable behaviours facilitates discussion, assessment and modelling of professionalism in both medical education and clinical care (Green et al. 2009).

My colleague van Mook et al. (2009) indicated a trans-Atlantic conflict of terminology. The Americans tend to use the term "*professionalism*" in their literature which is mainly a theoretical construct, and described in abstract and idealistic terms. The Europeans used "*professional behaviours*" to frame professionalism in observable actions that can facilitate learning and assessment. Perhaps the Europeans were more precise than the Americans when setting expectations for medical professionalism, but there is a need to acknowledge both terms to indicate the overarching attributes and the tangible behaviours. Professionalism values and attributes

have to be linked to specific behaviours. For instance, responsibility is manifested by "*arriving on time*" and "*following through on tasks*" (Kirk 2007). When changing focus from values to behaviours, the sight of the overarching values should not be lost, because behaviours tell students "*what*" to do, while values explain the rationale "*why*" they should do so.

Tip 8

Provide learning opportunities appropriate to the level of the learners

While the cognitive base of professionalism (Tip 2) must remain constant, the capacity of the learners to internalise professional values and reflect on experience varies according to their educational stages and professional maturity. Professionalism has to be integrated in every course and activity throughout the years of medical education (Wear & Castellani 2000). Learning opportunities for professionalism can be planned in five phases, as follows:

Orientation on admission

Professionalism can be introduced to medical students in a number of approaches. The "*White Coat Ceremonies*" are widely prevalent as a celebration of matriculation in medical schools to mark the beginning of educational, personal and professional formation processes (Karnieli-Miller et al. 2013). The "*Swearing of Oaths*" is another symbolic ritual where students repeat certain phrases that launch the process of their professional identity transformation into doctors "worthy of trust" (Kao & Parsi 2004). In contract to these passive activities, the "*Mission Statement Day*" is an exceptional opportunity to help students express their own mission statements as a spark for self-reflection and the exploration of personal values (Kenyon & Brown 2007).

Early undergraduate years

Authors used to focus on teaching professionalism in the clinical arena, but there are "neglected opportunities" for teaching professionalism in basic sciences (Macpherson & Kenny 2008). For instance, Neurophysiology courses may embrace discussions around brain death and vegetative state with its ethical dilemma (Siegler 2002). Even courses such as Gross Anatomy that, in the past, offered *pure content*, can be used to introduce students to professional values and behaviours such as: respect for human tissue, fulfil the expectations of the donors by dissecting with purpose and preserve confidentiality of the identifying information of the cadaver (Derstine 2002; Bryan et al. 2005; Escobar-Poni & Poni 2006; Lachman & Pawlina 2006).

Late undergraduate years

Hojat et al. (2009) recognised "*the devil in third year*", when a significant drop in empathy scores among students that persist till (and perhaps beyond) the day of their graduation. Ironically, as the curriculum is shifting towards patient-care activities, students gradually abandon their ideal notions on professionalism and develop a sense of cynicism, with a decline of empathy and moral judgment (Kirk 2007; Hegazi & Wilson 2013). Professionalism can be taught through vignettes either written, displayed in role-plays or recorded video from real practice (Boenink et al. 2005; Bernabeo et al. 2013). Popular medical drama can also present a wealth of situations depicting un/professional manners and selected clips can be used as triggers for reflection on specific professionalism dilemmas or discussing particular behaviours (Pavlov & Dahlquist 2010; Weaver & Wilson 2011; Hirt et al. 2013).

Residency training

Residents are *immature* professionals who practice under supervision (Hilton & Southgate 2007). Residents are vulnerable to burnout, because of the long working hours and excessive clinical and non-clinical responsibilities, tough competition in assessment, humiliation by supervisors and very little support or time to think, relax and reflect on their emotional involvement with patients (Stephenson et al. 2001). As they encounter more ill and dying patients, residents adopt a *clinical detachment* approach as a defensive strategy to preserve their emotions and to look objectively at, and think dispassionately about, their patients (Coulehan & Williams 2001; Stephenson et al. 2001). Residents tend to transform patients into analytic objects or room numbers and think of a procedure as a technical event to avoid sensitive contact with patients and they eventually develop a *non-reflective professionalism* approach to their practice (Stephenson et al. 2001).

Teaching professionalism to residents should enrich the reflective element of their experience to transform "*Patients Unmet Needs*" (PUNs) into "*Doctors Educational Needs*" (DENs) (Gammon 2001) and reward residents with the positive role-models in practice from patient care perspective (Tip 5). Joyner & Vemulakonda (2007) also reminded us to include residents and clinical preceptors in faculty development programs for professionalism (Tip 6).

Independent medical practice

Independent practitioners can transform the principles and ethos of professionalism into applied concepts and rational behaviours in reality, as they develop what is called "*practical wisdom*" (Hilton & Southgate 2007). By experience and reflection on experience, they learn which rules to break, when to do so and to what extend in order to accommodate reality at hand (Stephenson et al. 2001). They recognise their potentials and limitations, as there is no cure for all human illnesses. They also learn to live with uncertainty and develop an insight to accept and expect inevitable consequences.

Professionalism, therefore, should be presented to practitioners from a more fundamental and comprehensive standpoint. Teaching professionalism should not only focus on the perspective of "*what-to-be*" (attributes) and "*what-to-do*" (behaviours), because the definitions of "what" change over time in an evolving social context. For physicians to be able to continue incorporating desirable attitudes to meet the societal expectations, they must develop a "*know-why*" perspective as well (Nomura 2008). Physicians should conceptualise

professionalism as a dynamic, evolving, and multidimensional construct (Hafferty & Castellani 2010).

Tip 9

Allow structured time for guided reflection

Reflection is a metacognitive process that creates greater understanding of self and situations to inform future action (Sandars 2009). It is the process of analysing, questioning, and reframing (real or simulated) experiences to make an assessment of it for the purposes of learning (*reflective learning*) and/or to improve practice (*reflective practice*) (Aronson 2011). Effective reflection, then, requires structured *time* to question actions, underlying beliefs and values and to solicit different viewpoints (Stern et al. 2008; Gaiser 2009).

Reflection-*on*-action, is about thinking back on what was done in order to discover how one's knowing in action may have contributed to an unexpected outcome, while reflection-*in*-action is a hallmark of professionals where learners instantly connect with their feelings, emotions and prior experiences to attend to a current professionalism dilemma (Stark et al. 2006). Hodges (2014) recently catalogued four practices/purposes for reflection, which are: reflection as *metacognition* (think aloud), as *mindfulness* (spiritual guidance), as *psychoanalysis* (seeking interpretation for own thoughts), and as *confession* (seeking judgment for own behaviours). Teachers, therefore, should be trained to use reflection wisely to serve any of the above purposes, whenever indicated. Students also should be guided to improve their reflective abilities, perhaps with the use of a battery of triggers (questions) to stimulate guided reflection on professionalism vignettes (Boenink et al. 2005; Al-Eraky et al. 2015).

Tip 10

Evaluate the outcome, provide feedback and suggest appropriate remediation plans

Evaluation of professional attitudes and behaviour is integral to teaching professionalism (Cruess & Cruess 2006) and assessment has to be done at different levels: individual, interpersonal and societal-institutional (Hodges et al. 2011). In line with Tip 7, assessment and feedback should focus on behaviours, not attributes. Students may argue if they have been labelled as "*irresponsible*", but they usually accept remarks on specific observed behaviours, such as, "*You forgot to check on Mrs. Jones' lab work, which is essential to follow up her condition*". This type of feedback does not indicate that the student has a flaw in character; rather, it implies that he or she didn't exhibit the ideal behaviour in that situation, but is likely to do so next time (Kirk 2007). Students and residents with persistent lapses of professionalism have to be documented and closely monitored. A well-structured mentoring, remediation and probation plan is integral to teaching and assessing professionalism (Domen 2014). Teachers and programme directors may use non-threatening statements when discussing lapses in professional behaviours, as suggested by Buchanan et al., (2012), such as:

- "You don't have to agree with me, but I want you to understand me".
- "I am not saying you are totally at fault but we need to work together to help you understand what is viewed as a professional lapse".
- "If you were on this side of the desk, how would you handle this issue?"
- "You may have meant it in another way, but that (behaviour) was perceived as being unprofessional".

Tip 11

Share your teaching experience

Share your teaching experience with your peers to create "*communities of learning*" and "*communities of practice*" in teaching professionalism in your specialties. Discuss what worked and what did not work and why with them and explore better approaches for future practice. Some methods may be more rewarding and effective than others. For instance, medical students considered clinically associated training (role modelling, case conferences) as *most effective* in teaching professionalism, multidisciplinary expertise approaches (discussion with ethicists, attorneys, chaplains) as *effective*, and formal didactic approaches (lectures, videos, grand rounds presentations) as *least effective* (Roberts et al. 2004; Birden et al. 2013).

Medical teachers can share vignettes, learning objectives, triggers used in reflection sessions and students' feedback on each vignette in a sort of a "*vignette bank*". Educationalists can also review the actual learning outcomes with the intended ones and amend the course in view of teaching experience, students' feedback and teacher's reflection. The experience in teaching professionalism can be documented and reported in scientific meetings and published in local, regional or international journals.

Tip 12

Consider the digital aspects of professionalism (e-professionalism)

The rapid emergence of social media, including Facebook, Twitter and YouTube, has added a new dimension to defining, teaching, and role modeling professionalism in the medical field, called: *e-professionalism*. Kaczmarczyk et al. (2013) defined *e-professionalism* as the attitudes and behaviours that reflect traditional professionalism paradigms but are manifested through digital media. In this new digital age, trainees and lifelong learners must learn to be mindful of professionalism while using social media in order to protect their privacy as well as the image of physicians (Baer & Schwartz 2011). Tech-savvy medical students, residents and practitioners need to learn what is and isn't appropriate to do on the Internet (Ross et al. 2013) and, therefore, awareness on "*e-professionalism*" has to be addressed early on as part of the first-year undergraduate medical students' induction programme.

The American Medical Association (AMA) (2011) indicated that the formal professionalism curriculum should include a digital media component, which could include instruction on managing the "digital footprint" and regulate e-professionalism, such as: (1) maintain patient confidentiality in all environments, including online environments, (2) use privacy settings to safeguard personal information, (3) consider separating personal and professional content online, and (4) maintain appropriate boundaries of the patient–physician relationship (AMA 2011). The gist of these instructions is to preserve the traditional core values of medicine (privacy, confidentiality, one-on-one interactions, and formal conduct) in the milieu of social media which promotes other values (sharing and openness, connection, transparency, and informality) (Gholami-Kordkheili et al. 2013).

Institutional responses to violations of e-professionalism have been escalated from filing a disciplinary notice and academic sanctions up to revocation of licensure (Kaczmarczyk et al. 2013). Some behaviours can be "*strongly discouraged*" such as: use of vulgar language, implying disrespect for any individual due to age, race, gender, etc., substance abuse, sexual promiscuity and posting unflattering material on another individual's website. While others have to be "*strictly forbidden*" and mandate disciplinary actions, such as: violating patient confidentiality, reporting private academic information and neglecting official work commitments when interacting online.

Authors usually discuss *challenges*, but few also admit the social media-related *opportunities*, such as: improvement in sharing information, access to care and quality of care (Gholami-Kordkheili et al. 2013). The social media and collaborative websites (*wikis*) act as knowledge bases for hard-to-find resources on professionalism and they can be used to foster positive group dynamics and peer-assisted learning (Varga-Atkins et al. 2010).

Conclusion

Teaching professionalism is challenging and it is conditioned with understanding its domains in a particular context. Professionalism has to be defined in view of each institution to develop the cognitive base for professionalism education. Professionalism must be taught across the medical education continuum in stage-appropriate learning opportunities. Role-modelling, reflection, institutional support and faculty development are key success factors in teaching medical professionalism.

Finally, teaching professionalism is not an end, but a means to *professional identity formation* (Cruess et al. 2014). The above 12 tips are meant to be applied with a greater logic beyond teaching professional attitudes and behaviours. Our future graduates should gradually think, act and feel like physicians (Wilson et al. 2013; Cruess et al. 2014) and learn to appreciate the significant roles played by members of other profession; like nurses (Helmich et al. 2010). Medical educators should help students to be sensitive to their emotions, maintain a portfolio of narrative reflections and suggest alternative interpretations that foster the development of desired professional identities (Helmich et al. 2012; Wong & Trollope-Kumar 2014). Teaching professionalism is not about doing the right things (technical intelligence) or doing the things right (emotional and intellectual intelligence), but it is one strategy to improve personal intelligence in order to shape the right future graduates (Harden et al. 1999). This is the implicit drive for the growing significance of addressing professionalism as a fundamental theme of medical education.

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