THE NEW ZEALAND MEDICAL JOURNAL
Journal of the New Zealand Medical Association

Professionalism in its time and place—some implications for medical education

Tim J Wilkinson, MaryLeigh Moore, Eleanor M Flynn

Abstract

Professionalism is fundamental to good medical practice but is multifaceted so observing that a person is professional in some areas will not guarantee that person would be professional in others.

Most definitions of professionalism include a commitment to self-monitor and to improve; some personal virtues; and effective relationships with colleagues, patients and people who are important to those patients.

In addition, it is suggested that expectations of professionalism may alter depending on context, both of time and place. Societal expectations relating to professionalism are likely to change over time and our expectations of individuals may alter according to the stage of training. The environment (the workplace, one's colleagues, the work tasks) is also highly influential on the manifestation of professional behaviours.

The medical profession's social contract in relation to professionalism will always need to be updated. The effect of time and place means that searching for innate or stable elements of professionalism, in order to predict subsequent behaviours, is therefore difficult. This has implications for the selection, education and assessment of medical students.

The focus should be on how to build adaptability and resilience to contextual influences; to identify those elements of professionalism that can be learnt; and build systems of assessment that reflect professionalism's multifaceted and contextual aspects.

Professionalism is fundamental to good medical practice. Although it is well described as an expectation in medical education, training and practice, it is notoriously difficult to define and assess.[1,2]

Because "professionalisms" is a clumsy word, there is a risk that professionalism is viewed in the singular, and not as being multidimensional. The multidimensional nature of professionalism[1] means a student or practitioner can be professional in some aspects and not others. More importantly, noting that a person is professional in one aspect is not sufficient to know that he or she will be professional in all aspects, or in all circumstances, or at all times.[3]

Discussions on professionalism are hampered by a lack of an agreed definition. For some, professionalism in others is simply "being like me" while for others it may be "going beyond the call of duty" and putting in the extra hours. Some may even go so far as to say it's everything about being a doctor. There are numerous consensus statements on professional behaviour in medicine.[4–12]

A systematic review of consensus statements on meanings of professionalism placed all aspects under one of the following five headings:[1]

- Adherence to ethical practice principles.
- Effective interactions with patients and with people who are important to those patients.
- Effective interactions with other people working within the health system.
- Reliability.
- Commitment to maintenance, and continuous improvement, of competence in one's self, others and systems.

Whereas many discussions on professionalism focus on the individual [3], we suggest that the commitment to achieving and maintaining competence and to continuous improvement applies also to the profession as a whole. An individual's commitment to self-monitor and improve one's own competence includes taking steps to remedy any areas of weakness. The equivalent commitment on the part of the medical profession as a whole forms the basis of the social contract it has with the community.

This self-regulation incorporates the expectation that it will set standards, monitor its members and take appropriate steps where standards are not met. When the profession falls short in this responsibility it is rightly criticised by the public. The public expects and deserves no less – it needs to have confidence that the profession and the professionals within it are acting in the best interests of the health of individuals and their communities and that there are internal mechanisms to maintain standards that do not rely on constant vigilance from outside bodies.

The key regulatory body for qualified practitioners is the Medical Council of New Zealand but other parties, such as the Universities and Colleges also play a role, especially during training.

When considering professionalism, both in relation to individuals and to the profession as a whole, it is necessary to consider not only the characteristics of the individuals but also the context, in terms of both time and place. Time and place interact with the person to influence not only what professionalism means or looks like on a particular occasion but also in ways that can hinder or help an individual to "behave professionally."

Students and practitioners might be professional in some situations and not others, and on some occasions and not others. Just because an individual is professional at one point in time does not necessarily mean he or she will be so in the future.

Time

Definitions and meanings of professionalism have changed over time and will continue to do so.[13,14] Examples include the concepts of altruism[13] and confidentiality - both undoubtedly remain fundamental to our understanding of professionalism but both now have meanings that are more nuanced and bounded than previously. It is

now widely recognised that there are appropriate and desirable limits to each of these concepts.

Confidentiality as a guiding principle requires interpretation and application according to the particular circumstance and is no longer an absolute value to be upheld in every circumstance. For example, where breaching confidentiality is necessary to prevent harm to the patient or others it may be permissible to disclose limited information to appropriate others.[15]

Not only does society's expectations of professionalism change over time, so too can the expectations of a person change over his or her training and career. Expectations of a student just entering medical school are different from those of a recent graduate and different again from an experienced practitioner. This is at least in part because some aspects of professionalism are learnt during training and also because expectations change according to the circumstances of the job.

Consider reliability. Reliability in a student can be considered indicative of appropriate professional behaviour; however the expectations of reliability are different for a student and a senior clinician at least in part because of the different consequences.

Unreliable students impact largely on their peers and their own learning, whereas the consequences of an unreliable clinician are primarily experienced by patients (and also colleagues) and are not simply inconvenience but include potentially serious adverse health outcomes. It takes time and experience to fully learn and appreciate the consequences beyond the "classroom"; in particular the consequences for patients. A true appreciation of this requires an actual sense of responsibility and duty of care toward patients.

There are however some aspects where the expectations of professional behaviour do not change over time. For example, from the outset, students should demonstrate respect, honesty and trustworthiness.

Place

Professionalism also varies according to place. Just as time refers to two concepts (stage of training/practice and time of society), so too place can have more than one meaning. Place can be thought of as both the clinical situation and the work environment. What is considered professional, or not, can depend to some extent on the context as different situations can require different responses in order for the individual to behave professionally.

Different circumstances not only might require different responses but also might hide or reveal different professional and unprofessional behaviours. Additionally different work environments can make it more or less difficult to achieve and demonstrate professional standards and behaviours.

As an example, the same truly professional doctor interacting with a patient in an outpatient clinic discussing a risky elective procedure will behave differently when managing the consent process in an unstable trauma patient in the Emergency Department (ED). The guiding principles of respecting patient choice and prioritising

the patient's best interests are the same but in attempting to honour them the doctor will have to behave quite differently.

Any judgement made about whether or not the doctor behaved professionally should take account of the context. Likewise, a doctor interacting with a patient who is polite and readily compliant can appear to behave quite differently when interacting with another patient who is more challenging in some way - perhaps intoxicated and abusive—and yet still be behaving professionally on both occasions. The guiding principles of professionalism remain the same but the behaviours observed will look quite different and should be judged within that context.

It is also suggested that different places (different circumstances) can reveal or unmask underlying personal attitudes and characteristics which impact on professional behaviour and potentially produce either lapses of professionalism or examples of exemplary or meritorious professionalism. This interaction of the person with place is discussed later.

The second notion of place is as a work environment. There is increasing acknowledgement that an institutional climate can be highly influential on the professional behaviours of individuals—it may be harder for individuals to act professionally if they work within unprofessional environments. [13 16]

The powerful effects of role models and of the hidden curriculum are well documented— the importance of respect for patients and colleagues can be taught but if students do not see this modelled or if they see that employers do not show respect to employees, then much of this teaching will be powerfully undermined.

The influence of place needs to be considered in undergraduate education when both teaching and assessing the professionalism of students; for example students may have difficulty learning to respect patients and their peers if they witness qualified doctors making disrespectful comments about their patients and their colleagues.

Person

While time and place might alter behaviours and expectations, the third variable in the demonstration of professionalism is the individual and the personal resources and flaws each brings to their studies or work. The extent to which any characteristic or trait can be said to be innate, either in all people or in an individual, can be debated.

Furthermore, even those aspects that may be innate may not necessarily be stable. They could be eroded or developed, dependent on the environmental learning (and unlearning) opportunities. This is consistent with the notion, first proposed by Aristotle, that virtues are acquired by repetitive practice: an individual becomes virtuous by repeatedly doing what a virtuous person would do; a person develops courage by repeatedly practicing being courageous or compassion by repeatedly being compassionate.[17] This is congruent with the notions of deliberate practice[18] in the development of musical performance skills and in clinical skills,[19] and of cognitive load theory [20] which suggest that at least some professional behaviours can be learned and consolidated by feedback to students.

This has implications for selection processes because any assumption that professionalism is innate and/or stable could also be associated with the assumption that it could be predicted better. However, if we accept that some aspects may be learned and change over time, then one of the challenges is to determine those aspects (if any) that might be stable and not amenable or vulnerable to change. Arguably, it is only those aspects that are stable that could therefore be used to predict subsequent behaviours, and be included in selection criteria.

Time/place/person interactions

Examples of the interactions of time, place and person are not difficult to find. Recall the scenario of a doctor challenged by an abusive intoxicated patient, perhaps in a busy chaotic ED. The culture of the department and the resources available to the doctor, plus the doctor's personal attitudes, values and virtues, and the stage of training and experience will all combine to produce a response which could be considered more or less professional.

The response might be calm, non-judgemental and focused on managing the total situation including the clinical issues, or undisguised anger, disrespect and confrontation escalating the aggression of the patient and potentially jeopardising the care and safety not only of the patient but of others in the department.

As another example, consider the impact of culture. Different cultural groups have different expectations in relation to professional behaviours. This will be the case whether the cultural group is defined by ethnicity or country of residence or any of the many other ways in which groups share identities and understandings. There is almost certainly more cultural variation in the meanings and understanding of professionalism than acknowledged in the definitions produced within the dominant medical culture and literature.[21,22]

The understandings and expectations are often not made explicit and can pose problems when interactions between individuals cross cultures and when medical professionals do not recognise that their understanding of professionalism might not be shared by their patient, or indeed by colleagues. Furthermore, the expectations of most cultures change over time just as medicine has and does.

Another example is social networking though the internet (such as Facebook®[23]). This provides a new context in a new time and with some new attitudes amongst individuals to issues such as identity, privacy and ways of relating to each other. It has arisen relatively recently and so our current expectations of professionalism will need to be reviewed in relation to these developments. New "rules" and expectations are needed and are being developed locally as well as internationally. [24,25]

Finally, recent developments in health systems have highlighted the importance of the team, not just the individual. Health outcomes (including adverse outcomes) are considerably influenced by the health system and by the interactions amongst health professionals, as much as they are by the competencies of individuals. A focus on the professionalism of individuals alone therefore risks missing the other major factors, including the team context.

Implications for the profession

Observing that professionalism is dependent on context, time and place, as much as it is on the person has very important implications for how expectations are defined. Expectations will change according to context and over time and will change according to current society and culture.[14]

Professionalism is therefore not static but a dynamic entity such that definitions and expectations need to be reviewed and revisited. This cannot occur in isolation from either its membership or from society and needs to be a negotiated process. The profession's contract with society is neither fixed nor unconditional. The profession needs a means by which it engages with society, as well as with its own members, to review and renew its social contract, and to ensure definitions of professionalism remain relevant meaningful and valued.

Implications for medical education

The observation that professionalism is dependent on context, time and place, as well as person, also has implications for teaching and learning, and for selection and assessment. Moreover, such implications will vary depending on whether we are concentrating on elements of professionalism or on episodes of lapses in professionalism.

Formal teaching and learning about professionalism is now well established in medical school curricula, although role models, the institutional culture, and the hidden curriculum may overpower most traditional teaching approaches.[3] There is a need for a firm theoretical foundation in professionalism to be laid down so that it is not left to chance or to serendipitous workplace encounters to ensure our students acquire and continue to develop their professionalism.

Furthermore, formal teaching sessions, debriefing and discussion groups can assist in making sense of the powerful forces at work in our workplaces that may act to reinforce or undermine professionalism. These considerations suggest that professionalism belongs to everyone and therefore should be integrated into all that we do. However, it also suggests that the teaching and learning of professionalism have their own special attributes and theoretical underpinning and therefore need their own curriculum time.

Should the teaching and learning of professionalism therefore be integrated or standalone? The answer is clearly both so that learning occurs in multiple situations and at different stages during the course. Nevertheless, there needs to be vigilance to ensure that the integrated component reinforces and does not undermine the core elements, and that the standalone elements are valued and not ghettoised.

Most selection processes occur in one time and place. It is unclear which elements of professionalism are sufficiently stable to be useful in predicting future behaviour. There is therefore a limit to the degree that selection processes can be expected to predict subsequent professional behaviours.

Research into the increasing use of simulations in selection processes (such as through multiple mini interviews[26]) will provide useful data on how predictive these measures are for subsequent professional behaviours.

The emerging data suggest such processes are predictive of some elements of academic progress such as knowledge and communication.[26,27] If it is accepted that professional behaviours are dependent on time and place, then one-off selection procedures face considerable challenges if they are to predict future professional behaviours.

Assessment of professionalism during a medical course may pose slightly fewer problems than assessment of professionalism for selection. In medical courses there will be assessment related to the formal learning of professionalism in the course, which needs to be related to both the content and context of the learning. There is also the issue of assessment of general professional behaviour against specified criteria during the course, which many medical schools are attempting to put in place.

There is emerging evidence that some behaviours within a medical course might predict subsequent unprofessional behaviours after graduation.[28,29] However, while some key behaviours (such as failure to respond to feedback[28]) have a high relative risk of predicting subsequent unprofessional conduct, the absolute risk of these behaviours is very small. Any tool able to predict in advance when these unprofessional behaviours might emerge would be a very good tool indeed.

Assessment programmes that wish to include professionalism need to take a multifaceted approach[30] using multiple tools[1], multiple observers, in multiple places, over multiple times. Such approaches, almost by definition, suggest that most of this needs to be in the workplace. Within medical courses there need to be "workplace equivalents": situations and behaviours in learning environments that might be able to be used as surrogate markers of workplace professionalism.

The crucial element to such a programmatic approach however, is to ensure that all the pieces of information gathered by these multiple assessments are joined together to inform considered and defensible decisions[31]. These all need to be backed up by defining and publicising the clear expectations of the programme. Assessment of professionalism therefore also needs a system by which such information is collated and recorded.[31]

Given that some expectations of professionalism change over time, there needs to be a debate about how these accumulated assessments can and should influence student progression to graduation. Is it fair to carry over assessments from one stage to another or should the slate get wiped clear at each point of progression? It also needs to be considered what sources of information and kinds of behaviours can be legitimately and fairly added to the total assessment.

Are students, or qualified practitioners for that matter, ever "off duty" from the point of view of being assessed with respect to their professionalism? Are there some behaviours which should always be admissible as evidence and others in certain contexts which should be forgiven or excluded? This means any system of assessment of professionalism needs a mechanism by which behaviours are not just recorded and

reported, but also interpreted, in light of the context, stage of training, any mitigating factors, and any other misdemeanours; and then acted upon.

Remediation of unprofessional behaviour in medical students will depend on the behaviour of concern, the context and any relevant mitigating issues. Medical schools are developing processes to ensure that unprofessional behaviour of a serious nature is recorded and is formally brought to the attention of the student, often through Fitness to Practise committees. As yet there is little published work on the types and effects of remediation. The pressing research issue is to gain a better understanding of which aspects are remediable and which are not.

An analogy has been drawn between the teaching and learning of medicine and the launching of a rocket.[32] The old model suggested that you need to provide the rocket with enough fuel to last its whole journey. It will take off with enormous force and gradually return to earth just as the fuel runs out. The analogy in relation to professional competence suggests that we need to equip our students with all the knowledge and skills they need for their professional practice. They would then be launched into their professional careers and hopefully the parabolic curve they follow would mean they would run out of this knowledge just after they reached retirement age.

The new model makes use of refuelling stations. A successful launch needs to provide the rocket with enough fuel to get to the next refuelling stage, and with the equipment to engage with refuelling stations so that it can remain in orbit and functional for as long as is needed. Likewise, the analogy for the new model of medical education suggests a medical programme needs to equip students with enough core knowledge but more importantly with the skills by which they can constantly engage with new learning throughout their professional life. This “new” model analogy also applies to professionalism.

Conclusion

We suggest that professionalism is a dynamic and situated concept – an interaction of time, place and person. The concept itself and its manifestation in an individual will change over time, just as the health environment will change.

Students cannot therefore be either simply selected for professionalism or equipped with all that they need at the beginning of their journeys. Instead, they need to develop an understanding of the contributors to professionalism, including an awareness of their own personal characteristics and attributes, and be supported to learn and grow into their professional roles.

They will need the flexibility and ability to recognise when professional expectations are changing, to make sense of those expectations, and to recognise when the context, including colleagues, is not conducive to professional behaviours. Ultimately they will need to develop mechanisms to remain adaptable yet robust and resilient throughout.

Competing interests: None known.

Author information: Tim J Wilkinson, Professor and Associate Dean (medical education), Medical Education Unit, University of Otago, Christchurch, New Zealand; MaryLeigh Moore, Senior Lecturer, Medical Education Unit, University of Otago, Christchurch, New Zealand; Eleanor M Flynn, Senior Lecturer, Medical Education Unit, The University of Melbourne, Australia

Correspondence: Prof T J Wilkinson, University of Otago, Christchurch, C/- The Princess Margaret Hospital, P O Box 800, Christchurch, New Zealand. Fax: +64 3 3377975; email: tim.wilkinson@otago.ac.nz

References:

1. Wilkinson TJ, Wade WB, Knock LD. A blueprint to assess professionalism: results of a systematic review. Academic Medicine 2009;84(5):551–58.
2. McGurgan PM, Olson-White D, Holgate M, Carmody D. Fitness-to-practise policies in Australian medical schools — are they fit for purpose? Medical Journal of Australia 2010;193(11/12):665–67.
3. Wearn A, Wilson H, Hawken SJ, et al. In search of professionalism: implications for medical education. New Zealand Medical Journal 2010;123(1314):1–10.
4. Australian Medical Council. Good medical practice: A code of conduct for doctors in Australia. Canberra, Australia: Australian Medical Council, 2009.
5. Frohna A, Stern D. The nature of qualitative comments in evaluating professionalism. Medical Education 2005;39(8):763–68.
6. Hilton SR, Slotnick HB. Proto-professionalism: How professionalisation occurs across the continuum of medical education. Medical Education 2005;39(1):58–65.
7. Jha V, Bekker HL, Duffy SRG, Roberts TE. Perceptions of professionalism in medicine: A qualitative study. Medical Education 2006;40(10):1027–36.
8. Kearney RA. Defining professionalism in anaesthesiology. Medical Education 2005;39(8):769–76.
9. Rabinowitz D, Reis S, Van RR, et al. Development of a physician attributes database as a resource for medical education, professionalism and student evaluation. Medical Teacher 2004;26(2):160–65.
10. Swick HM. Toward a normative definition of medical professionalism. Academic Medicine 2000;75(6):612–16.
11. Van De Camp K, Vernooij-Dassen MJ, Grol RP, Bottema BJ. How to conceptualize professionalism: A qualitative study. Medical Teacher 2004;26(8):696–702.
12. Royal College of Physicians. Doctors in Society: Medical Professionalism in a Changing World. Report of a Working Party of the Royal College of Physicians of London. London: Royal College of Physicians of London, 2005.
13. Hafferty FW, Castellani B. A sociological framing of medicine's modern-day professionalism movement Medical Education 2009;43(9):826–28.
14. Boyask D, Boyask R, Wilkinson TJ. Pathways to "Involved Professionalism": Making Processes of Professional Acculturation Intentional and Transparent. Medical Education Online 2004;9:13.
15. Health Information Privacy Code (New Zealand), 1994.
16. Hafferty FW. Beyond Curriculum Reform: Confronting Medicine's Hidden Curriculum. Academic Medicine 1998, April;73:403–07.
17. Darwall S. Virtue Ethics. Oxford: Blackwell Publishing, 2003.
18. Ericsson KA. Deliberate practice and the acquistion and maintenance of expert performance in medicine and related domains. Academic Medicine 2004;79(10):S70–S81.

19. Engel GL. What if music students were taught to play their instruments as medical students are taught to interview? Pharos of Alpha Omega Alpha Honor Medical Society 1982;45(4):12–13.
20. van Merriënboer JJG, Sweller J. Cognitive Load Theory and Complex Learning: Recent Developments and Future Directions. Educational Psychology Review 2005;17(2):147–77.
21. Cruess SR, Cruess RL, Steinert Y. Teaching professionalism across cultural and national borders: Lessons learned from an AMEE workshop. Medical Teacher 2010;32(5):371–74.
22. Hodges BD, Ginsburg S, Cruess R, et al. Assessment of professionalism: Recommendations from the Ottawa 2010 Conference. Medical Teacher 2011;33(5):354–63.
23. MacDonald J, Sohn S, Ellis P. Privacy, professionalism and Facebook: a dilemma for young doctors. Medical Education;44(8):805–13.
24. Anderson LC, Pickering NJ. The student code: ethical and professional expectations of medical students at the University of Otago. New Zealand Medical Journal 2010;123(1318):43–49.
25. Mansfield SJ, Morrison SG, Stephens HO, et al. Social media and the medical profession. Medical Journal of Australia 2011;194(12):642–44.
26. Siu E, Reiter H. Overview: what's worked and what hasn't as a guide towards predictive admissions tool development. Advances in Health Sciences Education 2009;14(5):759–75.
27. Eva KW, Reiter HI, Rosenfeld J, Norman GR. The Ability of the Multiple Mini-Interview to Predict Preclerkship Performance in Medical School. Academic Medicine 2004;79(10):S40-S42.
28. Papadakis MA, Teherani A, Banach MA, et al. Disciplinary action by medical boards and prior behavior in medical school. New England Journal of Medicine 2005;353(25):2673–82.
29. Papadakis MA, Arnold GK, Blank LL, et al. Performance during Internal Medicine Residency Training and Subsequent Disciplinary Action by State Licensing Boards. Annals of Internal Medicine 2008;148(11):869–76.
30. Wilkinson TJ. Assessment of clinical performance – gathering evidence. Internal Medicine Journal 2007;37(9):631–36.
31. Wilkinson TJ, Tweed M, Egan T, et al. Joining the dots: Conditional pass and programmatic assessment enhances recognition of problems with professionalism and factors hampering student progress. BMC Medical Education 2011;11(1):29.
32. Handfield-Jones RS, Mann KV, Challis ME, et al. Linking assessment to learning: a new route to quality assurance in medical practice. Medical Education. 2002;36(10):949–58.