

EDITORIAL



Professionalism — The Next Wave

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In their Medical Education article in the October 26 issue of the *Journal*, Stern and Papadakis make a number of observations about professionalism and the learning environments in which medical training occurs.¹ Like a growing number of medical educators, they recognize that considerable learning (some think most) takes place outside the domain of the formal curriculum and that such learning involves indoctrination in the unwritten rules of studenthood and medical practice.

Some medical schools and residency programs have acknowledged the existence of alternative, or shadow, domains of learning, whose lessons are sometimes collectively called the “hidden curriculum,” and have accepted responsibility for both understanding and modulating the effects of these domains on students’ knowledge, skills, and values. Included in this broadened curriculum are the lessons students learn as they witness conflicts between the expectations and ideals articulated in professional codes² and the behavior of individual physicians (particularly faculty members) and organizations as both go about the daily and concurrent work of medicine and education.

As we work to define, instill, and appraise professionalism as a core standard and competency, it is critical that we keep three interrelated questions in mind. First, how do we effectively define and assess something that is transmitted in a variety of learning environments through a wide range of both formal and informal, even tacit, educational practices? Second, how do we effectively assess something that may be conceived as both practice and identity? And third, how do we design a system of evaluation that assesses both learners and their learning environments?

There is much to be gained in simplicity and directness by highlighting behavior, as advocated

by Stern and Papadakis. Nonetheless, an essential element of medicine’s claim to professional status lies in the development of what might be termed a “professional self” in students — the internalization of the values and virtues of medicine as a discipline and a calling. It is not sufficient for students to acquire the knowledge, skills, and outward behavior necessary for practicing medicine. Being a physician — taking on the identity of a true medical professional — also involves a number of value orientations, including a general commitment not only to learning and excellence of skills but also to medical behavior and practices that are authentically caring.^{3,4}

These value orientations and motives are, in part, the product of professional learning and socialization, with medical schools and residency programs functioning as critical settings for the development of what Leach and colleagues have labeled the “habit of professionalism”^{3,4} — a professional self that is in accordance with the values that medicine has publicly identified as central to its organizational identity and to its contract with society.⁵ It is this underpinning that provides the necessary stability and generalizability when one has to step outside the realm of textbook medical practice and confront situations of uncertainty and ambiguity — which are, after all, the defining characteristics of real-world medical work.

In addition to assessing behavior, we can and should evaluate trainees’ motives and their learning environments. There is a meaningful (and measurable) difference between *being* a professional and *acting* professionally. It is certainly possible to behave professionally without having authentically internalized core values. Even if trainees exemplify the behavioral standards of profession-

alism, we must attend to such inconsistencies between the inner self and outward appearance, sending a message that authenticity is a matter of great concern.

There are several other reasons to assess factors other than students' behavior.⁶ One of these factors arises from medicine's compact with society: the profession's desire for autonomy is predicated on its promise to police itself in the public's interest.⁷ External controls, even within the occupation, have been deemed to be largely unnecessary because controls would be internalized as a core part of each practitioner's self, through socialization. We should therefore be asking our students, our faculty, and our practitioner colleagues whether they are, in fact, committed to the core principles that we hold to be "professional."

Second, a focus on behavior may neglect our pedagogical responsibility to assess and transform the learning environments our students must navigate. Indeed, one might argue that we should begin by assessing learning environments and do so until we get it right. It makes little sense to assess the professionalism of students within learning environments that are hostile to its precepts.

Third, personal reflection remains a core element of virtually all definitions of professionalism,

and we should tap the products of this reflection, not just its behavioral manifestations. Medicine is a moral community, the practice of medicine a moral undertaking, and professionalism a moral commitment. We should bear these fundamental truths in mind as we design our learning environments and seek to measure their effectiveness.

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