The Teaching of Professionalism During Residency: Why It Is Failing and a Suggestion to Improve Its Success

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Professionalism is one of the core competencies to be taught and evaluated during residency. A review of the literature suggests that professionalism is not completely understood or practiced. The teaching of professionalism has been incorporated into the educational programs for residents. However, residents learn from two curriculums: the stated curriculum and a hidden curriculum. The hidden curriculum represents the actions observed by the resident of the faculty in the hospital. The impact of this hidden curriculum upon professional behavior by the resident is significant. Due to the hidden curriculum, a possible means of improving professionalism involves the development of a program for faculty. This program must include not only topics but time for personal reflection of one’s knowledge and actions. Self-reflection allows for the development of a true understanding and practice of professionalism and may improve professional behavior.

According to the Merriam-Webster Dictionary, professionalism is the conduct, aims and qualities that characterize a group of individuals with a calling. An emphasis on the education of professionalism is a major curriculum change occurring in residencies approved by the Accreditation Council for Graduate Medical Education. A third party observer in an academic hospital in the United States is likely to witness residents receiving lectures in professionalism. These lectures discuss the importance of respect for the patient and for all members of the health care team. The classes also address cultural sensitivity, conflict resolution and communication. In addition to these classes, a third party observer is also likely to see an anesthesiologist and surgeon yelling at one another in front of the resident, or the anesthesiologist berating an anesthesia technician for the lack of availability of the fiberoptic bronchoscope. In the pain clinic, a senior resident tells a junior resident to ignore the patient’s complaint because people of that nationality exaggerate their pain. In both the classroom and the clinical setting, learning occurs and the resident was educated in professionalism. The concern from these examples lies in the material taught and learned. These examples represent a dichotomy in the education of medical professionalism.

Many physicians feel that professionalism consists mainly of a list of behaviors. The advantage to such a belief is its ease of teaching and evaluating. A checklist can be generated and used. Yet, the previous scenarios also highlight the ineffectiveness of this approach. This article begins with a description of the attempt to understand professionalism. After this discussion, the effect of the hidden curriculum upon the understanding and the practice of professionalism is presented. The hidden curriculum represents the actions of physicians in the clinical setting that is implicitly taught as compared to explicit teaching of lectures and discussions. The learning from the hidden curriculum occurs in the context of activities that residents encounter in the hospital. Once the hidden curriculum becomes unveiled, a successful program improving professionalism is possible.

UNDERSTANDING AND THE PRACTICE OF PROFESSIONALISM

Accrediting organizations for graduate medical education have increased the stake for the definition of professionalism. Residencies must have documentation that professionalism has been taught and evaluated during their training and then use these evaluations for program development. According to the Accreditation Council for Graduate Medical Education, professionalism is “respect, compassion, and integrity; being responsive to the needs of patients and society that supersede self interest; working effectively with others as a member or a leader of a health care team or other professional group.” While a list is helpful in describing professionalism, it does not define professionalism nor assist with its understanding.
An important step toward understanding professionalism was provided by Cruess et al. These authors emphasized the importance of “profession” in the word “professionalism.” The core of professionalism lies in the concept of profession, which represents a group of individuals with special knowledge and an obligation to apply this knowledge to society. The emphasis upon the obligation to society represents the essence of professionalism, as “professions and their members are accountable to those served and to society.” Society awards certain benefits to those of a profession and may withdraw these benefits if the obligation is not being fulfilled. Although many physicians and academic societies have tried to define professionalism, they have not been successful. The reason for this lack of success is that the essence of professionalism mandates a contribution from the people physicians are to serve. Another problem is its fluidity. Professionalism is affected by current society and represents a contract between it and the physician. Given that society continues to change, professionalism also continues to evolve. Like any contract, it is continuously renegotiated with terms and expectations changing.

The viewpoints of patients are frequently neglected in the attempt to understand professionalism. To correct this deficiency, one study queried medical educators, medical students, doctors, allied health professionals and lay people in regard to professionalism. Both patients and those in the medical field agreed with the importance of being honest and competent, but patients emphasized communication and the ability to reflect upon one’s actions. An outstanding example from the surveyed group was presented: “A measure of professionalism is how you deal with your mistakes and how you face that situation—Am I going to own up or am I not?” Patients want their physicians to reflect upon their actions. Reflection involves taking time to think about the days events and interactions with peers and patients. Such reflection encourages further investigation and learning. A physician who reflects upon the patient, medical knowledge and inner feelings is likely to act professionally. This process is known as metacognition, an internally conducted analysis of one’s knowledge. “The fundamental importance of the development of metacognitive skills is that learners (physicians) will be able to guide their own learning process, make appropriate decisions independently, and transfer skills to novel situations.”

THE TEACHING OF PROFESSIONALISM

The current curriculum in professionalism incorporates a list of behaviors and designs a learning environment around this list. The learning experience typically consists of lectures, discussions, and case presentations. The education in professionalism must be expanded beyond this form of didactics. Any venture into teaching should be grounded in theory, with professionalism being no exception. Cruess and Cruess argue that the teaching of professionalism is actually based in situational learning. According to Brown et al., situational learning is “a product of the activity, context, and culture in which it is developed and used. Given the chance to observe and practice in situ the behavior of members of a culture, people pick up relevant jargon, imitate behavior, and gradually start to act in accordance with its norms.” In situational learning, the students gain understanding from the teacher’s actions and responses rather than being instructed on how to act.

Situational learning provides the basis for the education of professionalism. Situational learning incorporates context and reinforces concepts through behaviors. While many have attempted to teach professionalism in the classroom with lectures, professionalism is learned in the hospital. This learning can be strengthened by incorporating group discussion. According to Lin, “group problem solving and peer interaction, such as discussion and controversy, can also result in deep understanding of what one is learning.” Time for insight and small group discussion complements the situational learning of professionalism in undergraduate medical education and may be applicable to graduate medical education. Small group discussions involve dividing the residents and faculty into groups to allow enough time for all to participate. These groups meet to discuss various occurrences and observations.

Group discussions should allow for members to share observed behavior in the hospital or clinic. However, certain occurrences may not happen during the resident’s time in the hospital. As such, a curriculum defining learning goals will guide discussions and will insure that all important topics are covered. The topics must be clinically relevant and as authentic to the learning situation as possible. Topics of concern for residents include interactions with medical students, communication, patient treatment, accountability, and conflict resolution.

Small group discussions have advantages. Eighty-two residents were randomized to one of two forms of teaching. One group received 1 h of didactics from the instructor. The other group was divided into smaller groups. In the second group, topics were presented and discussed by the learners. In the small group format, students were encouraged to interact with one another. Opinions were shared and topics analyzed. On written examinations, the small group format showed greater gains in knowledge than did the lecture format. Small group discussions encourage active engagement and require student participation. Despite this success, the residents did not like the small group format and preferred passive learning. This preference most likely reflects the minimal effort required for passive learning. Residents must be convinced of the value of small group discussion.
Small group discussion does have logistical difficulties. The group should allow all to participate. Small group discussion involves a significant time commitment from all participants. Finding this time is particularly problematic for graduate medical education. Residents have patient care responsibilities that must be acted upon immediately. Many problems cannot wait until the small group is finished. Hard work, long hours, and pressure for all aspects of the patient’s care divert the resident’s attention from small group learning. Other logistics include an increased need for faculty and space for a meeting. A significant commitment from faculty is also required. Although these barriers to its implementation are real, they are not insurmountable.

Assessment must be incorporated to ensure that the desired results are obtained. The assessment serves as evidence of whether the desired result has been obtained. There currently are no good means for assessment. One simple means of assessment would be to observe behaviors, but this can be problematic. If a resident knows an observation is occurring, the resident can fake professional behavior and trick the evaluator into thinking that the desired result has been achieved. Other authors have noted this finding. When medical students were asked to respond to videotaped vignettes on professional decisions, the verbal responses were different than the written responses. When preparing the written responses, students were informed that their responses were part of an examination and that their grades would be dependent upon their responses. Students were reporting what they thought the instructor wanted to hear rather than what they actually thought. It may be beneficial to observe over longer periods to see if the desired results have been incorporated.

An opportunity for education in professionalism is necessary. Without a curriculum, it does not happen. One-hundred forty-four residents participated in a study in which their medical knowledge was assessed by an in-training examination, and their empathy was assessed by the Interpersonal Reactivity Index. The Interpersonal Reactivity Index is a 28-item instrument with 4 different subscales evaluating various aspects of empathy. Both scores were obtained every 3 mo over a 1-yr period. During this 1-yr period, the residents’ medical knowledge increased by 8 points, whereas empathy decreased by 1.6 points. The program did not have a formal curriculum for knowledge or for empathy. The lack of curriculum should have resulted in relatively steady scores. However, the knowledge and empathy scores did change, one in a positive direction and one in a negative direction. There is an informal curriculum as “these data demonstrate that the environment may simultaneously promote competency in one domain (e.g., medical knowledge) and erode competency in another (e.g., professionalism).” There is a curriculum, one that is the antithesis of professionalism. It is frequently referred to as the hidden curriculum as it is not directly taught. The hidden curriculum is a strong one. Despite the presence of a curriculum in professionalism in 97 articles, researchers were unable to detect a measurable change in professionalism. This lack of change is attributed to the hidden curriculum. “Simply creating a new curriculum for students and residents may fail. Indeed, the problem lies not in what we fail to teach our students, but in what we teach them every day by our own actions and inactions in medical schools’ ‘hidden curricula.’” This hidden curriculum is a real phenomenon with significant impact upon the resident.

**THE HIDDEN CURRICULUM**

While relatively recent to the medical literature, being described in 1994, it is a well described phenomenon in the education literature, appearing as early as 1930. The hidden curriculum involves the knowledge taught through actions and words in the clinical situation. The hidden curriculum is a by-product of situational learning. As stated by Brown et al. “students can quickly get an implicit sense of what is suitable . . . what is legitimate or illegitimate behavior . . . what they pick up is a product of the ambient culture rather than of explicit teaching.” The residents observe the faculty and learn about professionalism from their actions and from the consequences of their actions. In medicine, patients receive care from a health care team, which has many individuals of varying seniority. These characteristics establish the perfect foundation for a hidden curriculum. As highlighted by Marsh, “these three elements of ‘crowds,’ ‘praise,’ and ‘power’ gives rise to norms of behaviors, values, and norms which are initially completely unknown to the students.” The current means of providing health care, as well as of teaching medicine, provide the perfect substrate for a hidden curriculum.

The faculty are frequently unaware of their role in the hidden curriculum. Faculty represent the role model for the resident. “We are teaching far more than we know. Every word we speak, every action we perform, every time we choose not to speak or act, every smile, every curse, every sigh is a lesson in the hidden curriculum.” Residents also participate as teachers and have an influence on the medical student. In a qualitative study, six medical teams were followed and observed during their work day. The informal (hidden) curriculum extended to the time periods when the residents discussed patients or ate meals with the medical students.

An example of the hidden curriculum in action was provided by Lingard et al. These authors studied team communication in the operating room by observing video recordings of 128 h of operating room interactions. The authors identified several episodes of tension and noted how the tension spread to other
members in the operating room. These episodes of tension tended to be initiated by the senior member of the team and generally a novice was involved. After being berated by the attending, the surgical resident then berated the nurse after the attending left. The resident was in the operating room to learn surgery, but he/she also learned about communication and that it was acceptable to be impolite. The hidden curriculum had its effect on this novice. This person also probably may have attended lectures on the importance of positive communication and respect for other members of the health care team. It was the role model who had the greatest impact.

Given the impact of the hidden curriculum, professionalism seems to be in trouble. A survey was sent to trainees in England regarding bullying.25 The question posed was, “In this post, have you been subjected to persistent behavior by others which have eroded your professional confidence or self-esteem?” The response rate was 72% of the 3779 residents surveyed, with 18% of respondents reporting a bullying episode. Sadly, the bullying was done by a senior faculty member in 27% of the cases. Given the impact of the hidden curriculum, these numbers are deeply concerning and create a challenge that requires confrontation.

POSITIVE ROLE MODELS

The hidden curriculum emphasizes the impact of negative statements and actions upon the student by the role model. Both negative and positive role models also teach in the hidden curriculum. Positive role models are beneficial for both the teacher and the student. There is a reciprocal influence, in which learning occurs both by the student and the teacher.26 When queried about factors that identify an outstanding faculty member, residents listed: listens well, inspires trust, demonstrates respect, and answers questions directly.27 These characteristics are those which most would also list as professional. It is hoped that, if residents are able to identify the characteristics that define the professional faculty member, they can also learn from them. Positive role models possess dignity and self-respect.28 Although these characteristics represent the impression of residents, it is interesting to compare them to what a faculty member would consider as professional. Faculty at an academic institution were asked about the single value or quality that they try to pass on to residents.29 The responses fell into four categories: caring, respect, communication, and integrity. It seems that the faculty and residents are in alignment with the idea of the professional faculty member who is a good role model.

UNVEILING THE HIDDEN CURRICULUM

Given that residents are able to identify the qualities of a professional physician and that physicians try to teach professionalism through their actions and words, why does the hidden curriculum still exert its influence? The problem is in its implicit nature. In the previous example, faculty tried to impart these qualities to the resident without informing the resident of the desired goal. Residents need to be informed of the expected outcomes of the teaching. It is time to uncover the curriculum for all to see. The goal of professional behavior was disclosed to both residents and faculty in a department of urology.30 The residents and faculty designed and participated in a curriculum to assist with their professional development. All members of the department, both faculty and residents, participated in the curriculum. Two important results occurred: professionalism scores improved and variability of scores decreased. By making the desired goals explicit and by the incorporation of the entire faculty, residents appeared to perform more professionally. As these scores were generated every 3 mo over a year, it was hoped that they accurately portrayed the resident’s true behavior rather than a faked behavior that occurred during an isolated observation. Although a potential positive bias may have been created by having longitudinal evaluators, the decreasing variability of faculty scores suggests that a unified definition could be obtained.

The above approach represents one department’s effort. Can this activity be applied to a larger environment? Suchman et al.31 presented their work at the Indiana University School of Medicine. At this institution, a team of attendings, residents, and medical students interviewed individuals concerning the hidden curriculum. From these interviews, the key themes were identified and a presentation was prepared. This presentation was given multiple times and multiple places throughout the medical center. A written document was also prepared and given to every worker in the health care system. The key themes were collegiality, commitment, and respect. The team then performed observations after the presentation and noted change in the health system, with an increase in the administration of praise as well as a commitment to excellence. One participant stated, “Now that I see how good we really are, I have to ask myself why we tolerate it when people aren’t as good as this. I can’t just look on quietly anymore when people are disrespectful or hurtful. It’s no longer okay to remain silent; this is too important.”31 In this health care system, a successful professionalism initiative occurred according to this participant. Negative interactions would not be tolerated with the participating correcting episodes of disrespect. The hidden curriculum is no longer hidden nor tolerated.

The unveiling of the hidden curriculum is important to improve professionalism. The hidden curriculum is not readily accessible. A tool to characterize a medical school’s hidden curriculum was developed.32 The authors were not able to address all areas and focused upon role modeling, students’ patient-care experiences and perceived support for students’ own
patient-centered behaviors. Third and fourth year medical students were surveyed. Using factor analysis, 29 items were selected for the final tool. The final survey was reliable with a Cronbach’s α of 0.93 for role modeling, 0.70 for students’ experiences, and 0.85 for patient-centered actions. The final instrument was validated by comparing the results to a poll of members of the American Academy on Physician and Patient and of faculty of the Bayer Institute for Health Care Communication, two organizations devoted to teaching patient-centered care. The tool identified deficient areas and is useful for design of a curriculum as well as assessing its effect.

As the hidden curriculum becomes uncovered and as the importance of self-reflection is recognized, it becomes clear why previous attempts in the education of professionalism have failed. These curriculums have focused upon the learner and attempted to instill behaviors. Various qualities were identified and lectures/discussions were organized. These behaviors were not positively reinforced in the clinical setting by the faculty, resulting in the lack of learning. Therefore, to improve professionalism, a curriculum must be added for the faculty as the faculty are the role models as well as the teachers of the hidden curriculum. The curriculum for residents will be enhanced by this curriculum for the faculty. Also, the impact of the curriculum for faculty may be assessed by following resident evaluations in professionalism.

A CURRICULUM FOR FACULTY IN PROFESSIONALISM

If role models represent an important means for educating professionalism, why do negative actions seem to have a much stronger influence on the learner rather than positive actions? Paice et al.33 address this issue. They state that students are able to identify the qualities of an outstanding physician. Yet, they are not as impressed by these physicians as they are by physicians with responsibility and status. Negative actions by the physician leaders have a greater influence. For example, an anesthesiologist yelling at a technician becomes more accepted by the residents when it is the chairman rather than a member of the faculty. The curriculum must be embraced by the leaders in each department as these individuals are the ones with the greatest influence on the learners. The authors also note the lack of training for role models. Hence, the curriculum in professionalism must incorporate this training. Many faculty do not realize that they are role models. The curriculum must make them comfortable with this concept. Leaders in medicine must embrace the curriculum as these individuals are the most influential.

The curriculum must be based upon current realistic topics and must provide time for reflection. Review of real occurrences allows for the development of new approaches. Reflective thinking is difficult to master, especially in medicine where society expects the doctor to have the correct answer all the time. One of the first steps in the reflective process is the relinquishing by the individual of the superiority of knowledge.34 The individual must recognize that knowledge is uncertain and incomplete. Many of the truths that faculty learned during residency have been proven wrong. Reflective thinking will question not only knowledge, but also judgment and reasoning.35 Reflective thinking will question not only knowledge, but also judgment and reasoning.35 Reflection allows one to critique the decision-making process. Reflection is at the heart of medical practice that considers the patient as a valued human being and the physician as a participant in this individual’s life. The first sessions in the curriculum must allow the faculty to adjust to the idea that they will have to question their practices and beliefs.

Faculty who care for patients and who supervise residents are the ideal candidates for a curriculum in professionalism. They have the clinical experience as well as a solid knowledge base that can be questioned. Having completed their training, they should have the confidence to question their abilities and their knowledge. Hopefully, they also have the desire to improve themselves. Traditionally, faculty have been absent from this curriculum. Other than providing an occasional lecture or discussion, the faculty do not have a significant role in the current curricula. Faculty development also has been absent from curricula in professionalism. As a faculty member in a medical school, it is difficult to model a role when one is unclear of the role being modeled. It is time for a curriculum for faculty.

It is possible to teach reflection. Residents at seven different internal medicine residencies were surveyed regarding their training experiences and personal growth.36 Individuals with high personal growth scores also felt that reflection was taught during residency (odds ratio, 2.9; CI 1.1–7.4) and also were likely to have a strong desire to develop personally and professionally (odds ratio, 2.2; CI 1.1–4.1). The requirement of reflection for professional growth is clearly established. An added benefit to the training in professionalism was identified. Residents developed a greater satisfaction with their career choice. Professionalism is not only about improving relations between patients, physicians, and nurses, but also about development of the person. Professionalism instills pride in career choice and enjoyment in the work. The assessment from these individuals as well as self-assessment determines the impact of the curriculum.

Success in personal growth has also been demonstrated in faculty in a survey of faculty belonging to a group with an interest in professional development.37 Faculty were asked to submit stories regarding personal growth, and these stories were analyzed qualitatively. Several themes emerged from the study. Personal growth and professional development begins with a powerful experience followed by introspection and helping relationships. This type of learning has
been termed transformational learning. Transformational learning involves an experience which leads to new understanding and meaning.

There are several benefits of a curriculum in professionalism for faculty and they are not limited to becoming a better physician role model and teacher. Faculty are also asked to evaluate residents in professionalism. Currently, the evaluations are haphazard as the meaning of professionalism is individualistic. With a group, a consensus can be achieved. Also, a witnessed lapse of professionalism by a resident can be presented to the group. The episode and its remediation can be discussed by the group.38

A barrier to this curriculum in professionalism is time. It takes time to meet and time to seriously reflect. Long days, increased patient loads, and the increased demands of paperwork make the implementation of the curriculum difficult. Although difficult, it is not impossible. The decision of whether to implement a curriculum depends upon the chairman’s guiding principle. Leaders in anesthesiology must know what is important and then must do it. What is the mission of physicians and of the training of future physicians? It has to be to provide the best care and to promote health to all patients regardless of race, gender, and ability to pay. This goal represents one aspect of the true vision of medicine. All of the rest are distractions that keep the physician from fulfilling the mission. Professionalism and a dedicated curriculum for professionalism for the faculty allow for the achievement of the desired result. The leaders of anesthesiology must provide the time and opportunity for this curriculum.

CONCLUSION

Physicians may think of a list of behaviors when defining professionalism. These physicians cite communication, respect, patient care, and medical knowledge as the hallmarks of professionalism. Licensing agencies as well as medical education societies look for professionalism and its teaching in these lists. Curriculums are designed around these lists, and lectures occur. Residencies are satisfied with this approach as it is felt that this core competency is taught. Yet, despite these efforts, one does not see a change in understanding or practice of professionalism. These curriculums consistently do not achieve the desired goal of improving professionalism.

The problem is that physicians are searching for professionalism in the wrong place. It is not found in the lists of qualities. It is found in the quiet moment in which the physician reflects upon the day’s occurrences. The successful curriculum in professionalism guides and provides for reflection. Reflection is the driving force for change. During discussing and thinking, physicians are able to question their abilities. It is this questioning that leads to personal growth. It also encourages advancing one’s medical knowledge. Patients benefit by the improved care, while physicians benefit by the personal satisfaction and pride in career choice.

The curriculum must begin with the faculty. Students clearly model the faculty. The faculty teach in the curriculum, not only by what is stated but also by what is done. Negative role models, the primary teachers in the hidden curriculum, must be changed to positive ones as faculty are the ones who students aspire to become. If faculty do not practice and embrace professionalism, no formal curriculums of lectures espousing the principles of professionalism will be successful. This opinion highlights the strength of the hidden curriculum on the resident.

The hidden curriculum represents the actions and words of the faculty. It is time for this hidden curriculum to become unveiled. Residents need to be informed of the expected actions while faculty need to be informed of the expected behavior. The most important participants are the leaders as these individuals are those who are most closely modeled. Small groups provide an opportunity for physicians to discuss and reflect upon current situations. The groups must have an agenda but also must provide time for the group to discuss recent events. While small groups for the faculty are the most important, lectures are still needed. A true learning environment in professionalism is possible and incorporates faculty development, reflection, and discovery.

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