ORIGINAL
ARTICLES

Rethinking Professionalism in Medical Education Through Formation

Timothy P. Daaleman, DO, MPH; Warren A. Kinghorn, MD; Warren P. Newton, MD, MPH; Keith G. Meador, MD, ThM, MPH

BACKGROUND: Contemporary educational approaches to professionalism do not take into account the dominant influence that the culture of academic medicine has on the nascent professional attitudes, beliefs, and behaviors of medical learners. This article examines formation as an organizing principle for professionalism in medical education. Virtue, the foundation to understanding professionalism, is the habits and dispositions that are fostered in individuals but that are embedded in learning environments. Formation, the ongoing integration of an individual, growing in self-awareness and in recognition of a life of service, with others who share in the common mission of a larger group, depicts this process. One model of formation considers a continuum from novice to more advance stages that is predicated on rules that must be applied in greater contextually shaped situations. Within medical education, formation is the process by which lives of service are created and sustained by learning communities that promote human capacities for intuition, empathy, and compassion. An imagined curriculum in formation would link the lived experiences of mentors and learners with an interdisciplinary set of didactic materials in an intentionally progressive fashion.

(Fam Med 2011;43(5):325-9.)

"My medical education over the past 4 years has not changed my concepts on altruism, compassion, and respect, but it has made me dislike discussing them."[1]

Medical schools are filled each year with students who bring remarkable promise for human service and enthusiasm for an education in the practices of caring. Yet the comment above is representative of the intellectual and emotional shift that many students experience: from intellectual eagerness to a focus on the rote acquisition of information, from being open-hearted to being emotionally closed, from idealism to cynicism about their chosen profession.[2] Several studies have demonstrated that the attributes that are held up as professional values, such as altruism and social mindedness, diminish as medical students advance academically.[2-4] A survey of students from six medical schools, for example, found that 62% of the respondents believed that some of their ethical principles had eroded during their education.[4] Such a shift in personal mores is not limited to the preclinical years; an alarming rise in self-interested attitudes among students has been reported as they assume greater responsibility in patient care.[2, 5]

Although multiple reasons may be offered as to why such change occurs, the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education have framed the issue around professionalism, which lacks a precise definition.[2,6-8] The Liaison Committee on Medical Education (LCME), for example, denotes professionalism as the development of explicit and appropriate professional attributes in medical students; however, each medical school is expected to define and measure their particular attributes in the context of the institution's mission as well as the community in which it dwells.[9] Consequently there are numerous curricula to teach professionalism,[10] as well as measures to assess programs designed to foster professional behaviors and attitudes.[11] The response of medical students to these initiatives, unfortunately, has been one of frustration and disdain.[12] Learners note that such approaches do not fully account for themselves as persons, and students have picked up the discord between the explicit professional values that they are taught, and

From the Department of Family Medicine, University of North Carolina (Drs Daaleman and Newton); Department of Psychiatry and Behavioral Sciences, Duke University Medical Center (Dr Kinghorn); and Department of Psychiatry, Vanderbilt University Medical Center (Dr Meador).

the hidden, yet dominant, influence that the culture of academic medicine has on their professional development.[7,13,14] Are there alternative ways of thinking about professionalism that can deepen the education of emerging physicians?[15]

In this article, we examine "formation" as an organizing principle for initiating and sustaining the personal and professional development of physicians. Our notion of formation shares characteristics with, but is distinguished from, the concept of professional formation—denoted by the moral and professional development of students, the integration of their individual maturation with growth in clinical competency, and the ability to stay true to personal values and core values of the profession[16-18]—through its location of individual development within academic medical environments. First, we introduce the concept of virtue and frame it around philosopher Alasdair MacIntyre's ideas of practice and institution.[19,20] We then discuss a perspective of formation that is informed by Hubert Dreyfus and Parker Palmer and argue that formation provides an integrative paradigm, both individually and from an organizational perspective, for the development of physician virtue. Finally, we provide examples of initiatives that are representative of formation and institutional change and comment as to how professionalism can be integrated within academic environments through the medical home.

Medicine as a Virtuous Tradition

A comprehensive review of medical education noted that all expositions of professionalism, whether from professional organizations, accrediting bodies, or individual points of view, essentially devolve into descriptions of a virtuous person as physician, as well as the ways in which a virtuous physician acts.[2] Understanding virtue, therefore, is a necessary foundation to how we think about professionalism.[21] Alasdair MacIntyre provides a useful framework for considering virtue through his concepts of practice and institution. A "practice" is a cooperative social activity that involves standards of excellence and guidelines.[20] Medical care is a practice in this way of thinking since it is the provision of assistance to those in need of care or cure from disease, disability, or dysfunction, and the health education and prevention of disease by persons who are knowledgeable and skillful in providing such assistance (ie, physicians).[22] A practice also involves the achievement of internal and external goods. Internal goods are those goods realized in the course of trying to achieve excellence in a particular form of the activity. In contrast, external goods involve property or possession, such as power, fame, and financial resources and are characteristically objects of competition.[20] For physicians, well-being, healing, and health have been proposed as goods internal to the practice of medicine while income and prestige are noted as external goods.[23]

To learn a practice well, an individual needs to develop the personal habits and dispositions necessary to attain the internal goods of the practice. These habits and dispositions, according to MacIntyre, are called virtues.[20] Lifelong learning, for example, is a virtue of medical practice, since physicians need to maintain a knowledge and skill level of contemporary approaches to care (eg, standards of excellence, clinical guidelines) that contribute to the internal goods of health and healing for their patients. However, in striving for internal goods, every practice, such as the practice of medicine, is dependent on relationships among those who participate in it; virtues both sustain and support these relationships.[20] A virtue of lifelong learning, therefore, would be marked by individual physicians that display an ongoing thirst for new knowledge, as well as communities (eg, physician groups) that sustain and reward this virtue, such as through incentives or time off for continuing medical education.

A practice exists in a complicated relationship with institutions, which MacIntyre describes as organizations characteristically concerned with external goods, such as money, power, and status. Institutions are both necessary for the sustenance of a practice and can be often corrosive of them. This inherent tension between practice and institution, in which the competitiveness of the institution threatens the ideals of the practice, is illustrated by the financial conflicts of interest in academic health centers (AHCs) that have escalated over the last decade.[24] In the face of these tensions, the virtues of medicine are critically necessary to sustain the integrity of medicine as practice against the potentially corrupting influence of medical institutions.[20] For medical learners, how can virtues be fostered within academic environments and linked to the most important factor shaping professional identity, the socialization process that emerging physicians experience during their clinical years?[25,26]

Formation and the Development of Physician Virtue

Virtues are always generated within groups of people capable of articulating and sustaining them.[27] They do not arise spontaneously and solipsistically but are instead embedded in a particular history, housed within institutions, and cultivated and honed from practical wisdom.[20] Formation provides a way of thinking about the development of physicians as persons, which occurs within communities of practice that are themselves shaped over time and have a shared history.[28] Hubert Dreyfus provides a model of formation that is relevant to the education of emerging physicians in practical wisdom.[29,30] In the model, there is a continuum from novice to more advanced stages of formation that is guided by rules that must be applied in increasingly complex situations.[29,30] For medical learners, this

progression from rule-based to context-based ways of thinking and relating trains those in formation to select information that is relevant within specific clinical moments.[29,30]

The developmental goals and processes are differentiated along each stage of formation. For example, the goal of the medical novice is the acquisition of information that provides a basic understanding of the ways in which health is maintained and how disease is diagnosed, assigned a prognosis, and treated. Currently, the novice is predominantly exposed to classroom and lecture instruction in the preclinical years, a process that decomposes health and disease and reduces the desired information into context-free features.[29] In contrast, the advanced beginner applies an understanding of acquired information by working through real clinical situations.[29] The acquisition of practical wisdom is interdependent with sites of medical care, as well as exceptional role models, which strongly impact the formative experiences of learners.[14,30-32]

Although the Dreyfus model is philosophical in nature, the roots of formation are found in the ways in which women and men are prepared for religious life. Formation within particular religious communities involves activities such as instruction, worship and prayerful reflection, and service.[33] However, religious formation is considered much more broadly as an intentional developmental process in the life course of individuals and in the communities in which they dwell. It may be thought of as the ongoing integration of an individual, who grows in self-awareness, with a group of companions who share both their interior and outwardly lived experiences as they participate in the common mission of the community.[34]

This perspective is congruent with Parker Palmer, who views formation as the process in which "one becomes who they are."[35] Palmer notes that as individuals grow into an "authentic selfhood, whether or not it conforms to some image of who we ought to be," we concomitantly find a way of authentically living out a life of service.[35] The activities of formation also involve reflection, growth in knowledge of self and service, but most importantly, an ongoing attention to the question, "Who am I becoming as I move along in this life of service?"[2,35] Unfortunately, according to Palmer, there are major challenges to initiating and fostering this inner work due to educational ways of thinking that limit human capacities for living fully and integrally.[35]

Formation is dependent on entering into intentional relationships; students are brought into relationship with teachers, with each other, and with the subject matter.[35] Here, participation in mutually responsive learning communities allow students and their mentors to draw on the full range of human capacities.[35] Although intellect, reasoning, and the senses are the prime areas of emphasis and development for contemporary medical learners, there are greater capacities, such as intuition, empathy, and compassion, which are human requirements for caring. If these capacities are to be tapped into and deepened, formation initiatives need to provide a way for learners to discover the creative tension between their limits and their potentials.[35] How can this be attained in environments responsible for medical education?

Imagining Formation in Medical Education

Any proposed program of formation needs to account for the hidden curriculum that is prevalent in medicine[36] and is found in the unscripted, highly interpersonal teaching that goes on in clinical settings.[6,13] The inherent tensions between the hidden curriculum and what is formally taught creates conflict and disillusionment among medical students and faculty.[3] For example, a recent study of five medical schools found that faculty perceive that their respective institutional behaviors are not well aligned with their personal values.[37] More directly and destructively, the hidden curriculum often impedes meaningful discourse surrounding clinical situations, crippling the socialization process that emerging physicians experience during their clinical years.[38]

Two well-regarded programs of professional formation—the Healer's Art course and the Relationship-centered Care Initiative (RCCI) at the Indiana University School of Medicine (IUSM)—have been developed in response to the hidden curriculum.[16] The Healer's Art course is an elective course for first- and second-year students that uses narrative and contemplative learning that enfolds students into a community of inquiry.[39] The RCCI initiative, in contrast, took an institutional approach at IUSM and sought to align the informal and formal curricula through culture change using an emergent design, appreciative inquiry, and complex responsive processes of relating.[40]

The common elements of the Healer's Art course and RCCI—the use of narrative, the creation of a community of learners, and the fostering of reflective processes—provide a foundation to cultivate the personal habits and dispositions, that is, the virtues of the practice of medicine. Since these components are variably and incompletely linked to the socialization process that physicians go through during their clinical training, it is uncertain if such habits and dispositions can be developed and sustained. The Dreyfus model, which was described earlier, provides a practical approach to the cultivation of virtue and may be found in the core curriculum of selected liberal arts colleges[41] that have integrated, sequenced programs of study that focus on examining the human condition from multiple disciplines.[42]

Longitudinal interdisciplinary core curricula, such as the doctor-patient relationship course in Harvard's New Pathway (NP) program, have the infrastructure to extend this model to medical education.[43] However, the immediate learning environment, whether it is a tertiary care center or

outpatient clinic, needs to come into play since it a critically important factor shaping professional identity.[25,26] It is here where the medical home has potential to become a distinctive and specific locus of formation in which mentors and learners maintain small-group relationships, reflecting on and discussing their clinical experiences.[28] A program of formation could be incorporated into the medical home by linking students' lived experiences with an interdisciplinary set of didactic materials and mentors in a progressive and intentional fashion. First-year coursework would broadly examine disease, illness, and suffering from various perspectives, such as the use of literature and patient narratives, as well as the population sciences of epidemiology and sociology. In place of standardized patients that are currently used to develop clinical skills, first-year students would be introduced to the experience of direct patient care as medical assistants in the medical home.

The second year of the program would explore how medical and public health care systems have evolved in response to disease and illness. Course content would include the history of medicine and the US health care delivery system; students would shift their experiential learning to medical home administrative settings. Students would continue to rotate among the traditional clerkships but still would regularly meet in small-group settings with their medical home mentors to reflect on and discuss their clinical experiences. In the third year, coursework would take up alternative approaches to health care, such as nursing, complementary and alternative medicine, and those found in other cultures. The fourth year would focus on an examination of the virtues of medical practice, incorporating principles of ethics, and clinical decision making. A hallmark of the program would be the focus on the "inner work," referred to by Palmer, by having students progress intentionally from rule-based to context-based ways of caring for patients.[29,30]

A Way Forward

To capture the enthusiasm and idealism of students entering medicine, and to prepare them for the life commitment that they are making, medical education needs to acknowledge that the most powerful learning is experiential and that learners are close observers of what actually goes on in academic environments.[7] If benevolence, compassion, and a commitment to justice are cultivated only within communities that are capable of embodying these virtues, educational programs need to find approaches that offset the hidden, informal curriculum that has taken root in academic medicine. Formation—medical learners, faculty mentors discovering who they are becoming as they move along together in lives of service within the environment of the medical home—offers a way to awaken, enrich, and sustain the virtues of both emerging and established physicians, and their capacities of caring, for the long haul.

CORRESPONDING AUTHOR: Address correspondence to Dr Daaleman, University of North Carolina, Department of Family Medicine, Campus Box 7595, Chapel Hill, NC 27599-7595. 919-966-3889. Fax: 919-966-6125. Tim_daaleman@med.unc.edu.

References

1. Wear D, Zarconi J. Can compassion be taught? Let's ask our students. J Gen Intern Med 2007;23:948-53.
2. Inui TM. A flag in the wind: educating for professionalism in medicine. Washington, DC: Association of American Medical Colleges, 2003.
3. Newton BW, Barber L, Clardy J, Cleveland E, O'Sullivan P. Is there a hardening of the heart during medical school? Acad Med 2008;83:244-9.
4. Feudtner C, Christakis DM, Christakis NA. Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development. Acad Med 1994;69:670-9.
5. Testerman JK, Morton KR, Loo LK, et al. The natural history of cynicism in physicians. Acad Med 1996;71:S43-S45.
6. Coulehan J. Today's professionalism: engaging the mind but not the heart. Acad Med 2005;80:892-8.
7. Ludmerer KM. Instilling professionalism in medical education. JAMA 1999;282:881-2.
8. Wynia MK, Latham SR, Kao AC, Berg JW, Emanuel LL. Medical professionalism in society. N Engl J Med 1999;341:1612-6.
9. Liaison Committee on Medical Education. Accreditation standards. October 30, 2009. www.lcme.org/functionslist.htm. Accessed March 23, 2010.
10. Kuczewski MG, Bading E, Langbein M, Henry B. Fostering professionalism: the Loyola model. Camb Q Healthc Ethics 2003;12:161-6.
11. Association of American Medical Colleges, National Board of Medical Examiners. Embedding professionalism in medical education: assessment as a tool for implementation. Baltimore, MD: Association of American Medical Colleges, 2003.
12. Leo T, Eagen K. Professional education: the medical student response. Perspect Biol Med 2008;51:508-16.
13. Brainard AH, Brislen HC. Learning professionalism: a view from the trenches. Acad Med 2007;82:1010-4.
14. Wear D, Kuczewksi MG. The professionalism movement: can we pause? Am J Bioethics 2004;4:1-10.
15. Kinghorn WA. Medical education as moral formation. Perspect Biol Med 2010;53:87-105.
16. Rabow MW, Remen RN, Parmelee DX, Inui TM. Professional formation: extending medicine's lineage of service into the next century. Acad Med 2010;85:310-7.
17. Wear D, Castellani B. The development of professionalism: curriculum matters. Acad Med 2000;75:602-11.
18. Cook M, Irby DM, O'Brien BC. Educating physicians. San Francisco: Jossey-Bass, 2010.
19. MacIntyre A. Dependent rational animals. Peru, IL: Carus Publishing Company, 1999.
20. MacIntyre A. After virtue: a study in moral theory. Notre Dame, IN: University of Notre Dame Press, 1984.
21. Pellegrino ED, Thomasma DC. The virtues in medical practice. New York: Oxford University Press, 1993.
22. Pellegrino ED. The commodification of medical and health care: the moral consequences of a paradigm shift from a professional to a market ethic. J Med Philos 1999;24:243-66.
23. Veatch RM, Miller FG. The internal morality of medicine: an introduction. J Med Philos 2001;26:555-7.
24. Rothman DJ. Academic health centers and financial conflicts of interest. JAMA 2008;299:695-7.
25. Bosk CL. Forgive and remember: managing medical failure. Chicago: University of Chicago Press, 2003.
26. Mizrahi T. Getting rid of patients: contradictions in the socialization of internists to the doctor-patient relationship. Sociology of Health and Illness 1985;7:214-35.
27. Kinghorn WA, McEvoy MD, Michel A, Balboni M. Professionalism in modern medicine: does the emperor have any clothes? Acad Med 2007;82:40-5.
28. Daaleman TP. The medical home: locus of physician formation. J Am Board Fam Med 2008;21:451-7.

29. Dreyfus HL. On the Internet, thinking in action. London: Routledge, 2001.
30. Leach DC. Professionalism: the formation of physicians. Am J Bioethics 2004;4:11-2.
31. Murinson BB, Klick B, Haythornthwaite JA, et al. Formative experiences of emerging physicians: gauging the impact of events that occur during medical school. Acad Med 2010;85:1331-7.
32. Wright S, Wong A, Newill C. The impact of role models on medical students. J Gen Intern Med 1997;12:53-6.
33. Barry WA. Jesuit formation today: an invitation to dialogue and involvement. Studies in the Spirituality of Jesuits 1988;20(5):1-50.
34. Barry WA. Jesuit spirituality for the whole of life. Studies in the Spirituality of Jesuits 2003;35(1):6-44.
35. Palmer PJ. To know as we are known. New York: Harper Collins, 1993.
36. Hafferty FW. Beyond curriculum reform: confronting medicine's hidden curriculum. Acad Med 1998;73:403-7.
37. Pololi L, Kern DE, Carr P, Conrad P, Knight S. The culture of academic medicine: faculty perceptions of the lack of alignment between individual and institutional values. J Gen Intern Med 2009;24:1289-95.
38. Stern DT. Practicing what we preach? An analysis of the curriculum of values in medical education. Am J Med 1998;104:569-75.
39. Remen RN, Rabow MW. The healer's art: professionalism, service, and mission. Med Educ 2005;39:1167-8.
40. Cottingham AH, Suchman AL, Litzelman DK, et al. Enhancing the informal curriculum of a medical school: a case study in organizational culture change. J Gen Intern Med 2008;23:715-22.
41. Boyer EL. College, the undergraduate experience in America. San Francisco: Jossey Bass, 1987.
42. St. Joseph's College. Core curriculum: for other educators. www.sainjoe/edu/academics/core/educators.htm. Accessed March 15, 2009.
43. Peters AS, Greenberger-Rosovsky R, Crowder C, Block SD, Moore GT. Long-term outcomes of the New Pathway program at Harvard Medical School: a randomized controlled trial. Acad Med 2000;75:470-9.