Medical professionalism - more than fitness to practise

Dr. David Owen, **Dr. Faith Hill** and **Dr. Chris Stephens**, School of Medicine, University of Southampton

The General Medical Council (GMC) and the Medical Schools Council have produced guidance on professional behaviour for medical schools and students.[1] The guidance focuses particularly on fitness to practise. While fitness to practise is vital for the protection of patients, we argue that it is only one aspect involved in the teaching and learning of professionalism.

Professional practice stems not only from external guidelines but also from an individual's personal reflection into their values and the personal insight they gain during their training. These reflections and insights may be called personal development and should form an integral part of training for professionalism. Personal development lays the foundation for the ongoing professional development that is necessary for clinicians to adapt and change according to the different requirements and expectations they will face during their professional lives.

This paper presents a model that the authors have found useful in developing the teaching of professionalism in the School of Medicine at Southampton. It presents a view of professionalism where values, behaviours and relationships are interconnected, interdependent and mutually determining, and where this is equally true of personal development, clinical practice and the individual's understanding of the organisations to which he or she belongs.

Professional values

There are two competing sets of beliefs concerning the way in which medicine establishes and maintains itself as a profession. From the first perspective, medicine is seen as predominantly a vocation which selects individuals who aspire to particular values, experience a calling to belong to a group that works with these values and undertake to learn the appropriate techniques and skills. The alternative perception sees medicine as predominantly a 'job', requiring technical and specialised training and individuals who will adopt and champion the values that are expedient in practicing their skill. In reality, the profession encompasses qualities of both a vocation and a highly skilled job. Moreover, as medicine encompasses a diverse set of roles, requires practitioners to behave in a variety of ways and to form professional relationships with diverse patients, it is arguably healthy for individuals to hold a range of different values. Individual awareness of personal values, and the maturity that comes from having reflected on personal strengths and weaknesses, are likely to serve patients better than any predetermined set of values and behaviours.

A dynamic model of professionalism

A consensus seems to be gathering that 'medical professionalism signifies a set of values, behaviours and relationships that underpins the trust the public has in doctors'.[2] A delicate balance has to be found between professional values, appropriate behaviours and clinical responsibilities.[3] Teaching this 'ecology of professionalism'[4] presents challenges further complicated by students, teachers and patients each emphasising different values as the most important.[5] When individual practitioners, their practice environments and the organisations that represent and regulate them have values that are aligned, a 'virtuous cycle' of personal, clinical and organisational development is established. Such values include collaborative decision-making, appropriate curiosity, importance of training and a culture of unbiased research and enquiry.

We have developed a model that depicts three areas of influence on medical professionalism. (See Figure 1.) The three are personal development, clinical practice and the individual's relationship to the organisations that employ and regulate them. Each is connected to the others. For example, when doctors experience burnout and depression within an organisation, they are more likely to perceive they have personally made errors and visa versa.[6] Box 1 describes some examples of learning outcomes for each of the three.
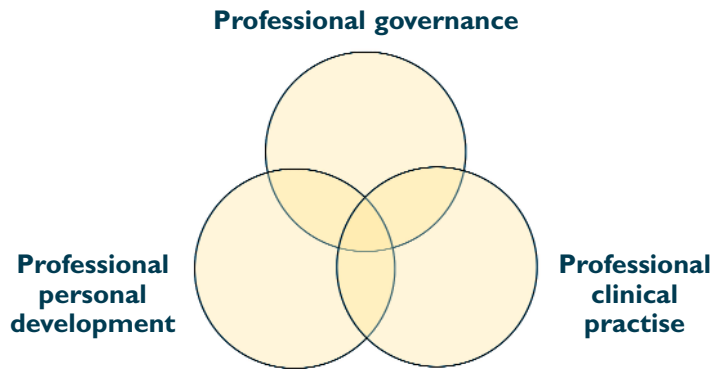
Figure 1: Professional clinical practice

Organisational development

"Medicine, like any cultural practice, is based on a set of shared beliefs and values, and is an intrinsic part of the wider culture of society."[7]

EXAMPLE LEARNING OUTCOMES

By the end of undergraduate training, a medical student should be able to:

- Describe how their future career fits in with the provisions of health and social care.
- Explain the function of the organisations that regulate, represent and employ them.
- Describe how as doctors they might interact with government and patient organisations.
- Describe the variety of roles and expectations that the public have of medical professionals in society.

Clinical practise

"If doctors don't provide a positive, patient centred approach, patients will be less satisfied, less enabled, and may have greater symptom burden and higher rates of referral".[8]

EXAMPLE LEARNING OUTCOMES

By the end of undergraduate training, a medical student should be able to:

- Describe how their personal values and attitudes influence the doctor - patient relationship.
- Reflect on the expectations patients are likely to have of doctors' behaviour.
- Explain how a health professional's wellbeing influences their ability to provide care.[9]

Personal development

'Burnout is common in physicians at all levels of training and practice, from medical students to department chairs' .[10]
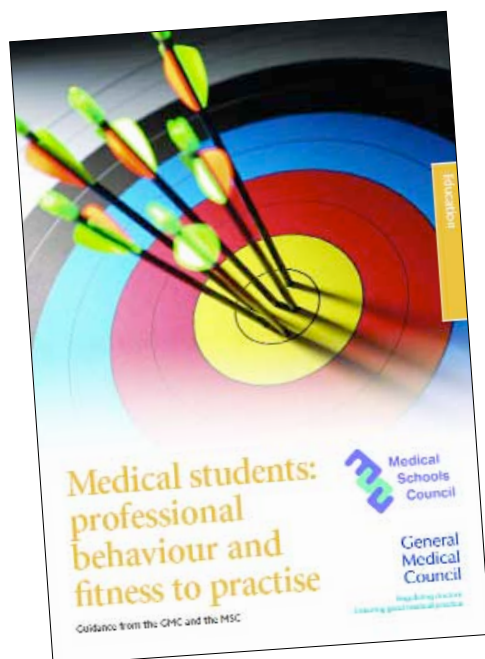
EXAMPLE LEARNING OUTCOMES

By the end of undergraduate training, a medical student should be able to:

- Recognise that some degree of stress is a natural part of training and may promote a physician's ability to perform under pressure.
- Identify and manage unhealthy levels of distress including emotional exhaustion, sleep deprivation, unrealistic patient expectations, work-life imbalances and be aware of how to support him or herself through these.
- Be aware of how they respond when caring for patient suffering and dying.
- Reduce the likely-hood of burnout, depersonalization, alcohol or other drug misuse in themselves and others.
- Be aware that physicians are themselves therapeutic instruments that require maintenance and renewal to remain effective.[11]

These learning outcomes are for illustrative purposes and not taken directly from the Southampton curriculum.

Box 1. Example learning outcomes for the three aspects of medical professionalism

Medical students: professional behaviour and fitness to practise

Guidance from the GMC and the MSC

Medical Schools Council

General Medical Council

Role modelling, reflection and cynicism

All three aspects of professionalism are commonly learnt through a process of role modelling and observing a community delivering and receiving care. Throughout their training, doctors move through a number of diverse clinical settings and meet many teachers and patients. They become involved in a 'community of practice' determined by varied beliefs and behaviours and influenced by different situations, social interactions and contexts in which they learn.[12] Students gradually become full participants within a culture through 'trying out' values and 'picking up' behaviours observed in 'role models'. Taking part in a wide range of experiences, including managing difficulties and mistakes, enables the process of professional development.[13] This 'situated learning' is frequently not part of the formal curriculum or identified in explicit learning outcomes but is none the less a vital part of medical training.

There are, however, important questions to be asked about such 'informal' learning. There is evidence of negative change during medical training, such as a reduction in empathy.[14] One study reported evidence indicating that 47% of students in the study felt pressurised to act unethically because of negative role models.[15] In another study it was reported that most medical students in the United States claim to have been harassed or belittled during their training.[16] We need to gain a better understanding of effects like these but we would contend that so long as the teaching of professionalism continues to rely on unconscious role modelling and situated learning, it will remain difficult to ensure that all students have adequate opportunities to develop appropriate values and attitudes or develop the reflective skills necessary to prepare them for a diverse and evolving profession.

Students need opportunities for mentoring and reflection on the role modelling and situations they have experienced. Guidelines on behaviour and lists of values the profession feel are important may be helpful if used to stimulate a process of reflection. However, if teachers and students associate the guidelines solely with rules on fitness to practise, they can serve to hinder reflection about the diverse values different individuals hold. Guidelines may also inhibit those teachers who regularly attempt to inspire students to gain insight into the values that underpin their way of working. For example, honesty is often regarded as a core value, but how might a doctor model those times when it is necessary to hold back from being (brutally) honest? Altruism is also frequently suggested as a core value but how, when it is required, do doctors learn to put their own health and well-being first? In practice, it is often when students encounter these and similar difficult choices that they learn most. It is vital to facilitate reflection at these times and we believe that this is a key educational role. It is also important to support and mentor students where their personal values do not neatly reflect the professional ones expected of them or when values and beliefs that might be long held are challenged.

Cynicism is evident where there is a difference between students' beliefs and feelings and what they say or reveal when being observed. The greater the fear of not meeting fitness to practise guidelines, the greater and more embedded the potential for cynicism. For example, doctors are often perceived by the public to be more trustworthy than other professions, with nine out of ten members of the public trusting doctors to tell the truth.[2] Can trustworthiness be assumed in those choosing medicine as a career; does it correlate with academic credentials; is it reflected in the behaviour of student doctors; how does it change during medical training and how can it be assessed? Are those who fail to meet a required level screened out and, if so, how? If values and behaviour exhibited in an examination, or when practice is being observed, are different from the normal daily practice of student or teacher then the situation may lead rapidly to a culture of cynicism.

Although mentoring is common in medicine, there is not the same culture of clinical supervision as in other health professions. Many medical students have high

expectations to get things right and find it difficult to discuss mistakes. Enabling teachers to mentor, support and supervise students should help students to learn to practise reflectively. This is more valuable than relying on fitness to practise. Indeed, over-relying on fitness to practise may lead to a scapegoat culture (there but for the grace of God...), where problems are seen as one-off issues that the rest of the profession can pigeon hole and disassociate with (we would never do that), while creating stress and fear (best keep quiet rather than ask for support or assistance). The early experiences students have at medical school are likely to set their expectations both of themselves and the level of support they can expect from organisations like the GMC.

Conclusion

There are important questions about the nature of medical professionalism and how it should be taught and monitored. The way doctors behave will be influenced by professional guidelines such as those issued by the GMC and the Medical Schools Council. But this contribution from the organisations that regulate and train doctors will be tempered not only by the influence of role models and learning in a variety of clinical situations but also from personal reflections and awareness. Enabling medical students to identify the values, behaviours and attitudes they hold and to reflect on how these interface with the values they observe during their training are important aspects of teaching professionalism.

Professional development is an integral part of becoming a doctor. What is at stake includes vital issues relating to standards of clinical practice and also the relationships that doctors have with their organisations and their own well-being. If medical schools are to prepare doctors for the future they need to adopt a broad approach that goes beyond guidelines and involves more than role modelling and situational learning. It is essential that students undergo a reflective process that enables personal growth. There is a possibility that over reliance on fitness to practise guidelines could inhibit broader professional development. How this issue is addressed is central to determining how the culture of medical professionalism develops.

For more information contact **f.j.hill@soton.ac.uk**

References

1. General Medical Council. *Medical students: professional behaviour and fitness to practise*. September 2007.

2. Royal College of Physicians. *Doctors in society: medical professionalism in a changing world*. December 2005.

3. Beauchamp G. 'The challenge of teaching professionalism.' *Ann Acad Med* Singapore 2004;33:697-705.

4. Goldstein EA, Maestas RR, Fryer-Edwards K, Wenrich MD, Oelschlager AA, Baernstein A, et al. 'Professionalism in medical education: An institutional challenge.' *Acad Med* 2006;81:871-76.

5. Wagner P, Hendrich J, Moseley G, Hudson V. 'Defining medical professionalism: a qualitative study.' *Med Educ* 2007; 41:288-94.

6. West CP, Huschka MM, Novotny, PJ, Sloan JA, Kolars, JC, Habermann, TM, et al. 'Association of perceived medical errors with resident distress and empathy.' *JAMA* 2006;296:1071-78.

7. Royal College of General Practitioners. *The Learning and Teaching Guide*. November 2006.

8. Little P, Everitt H, Williamson I, Warner G, Moore M, Gould C, et al. 'Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations.' *BMJ* 2001;323:908-11.

9. Shanafelt TD, Sloan JA, Habermann TM. 'The well-being of physicians.' *Am J Med* 2003;114:513-19).

10. West CP, Shanafelt, TD. 'The influence of personal and environmental factors on professionalism in medical education.' *BMC med ed* 2007;7:29.

11. Novack DH, Epstein RM, Paulsen RH. 'Toward creating physician-healers: Fostering medical students' self-awareness, personal growth, and wellbeing.' *Acad Med* 1999;74(5):516-20.

12. Brown JS, Collins A, Duguid S. 'Situated cognition and the culture of learning.' *Educ Researcher* 1989;18(1):32-42.

13. Lave J, Wenger E. *Situated Learning: Legitimate Peripheral Participation*. Cambridge, UK: Cambridge University Press, 1991.

14. Hojat M, Mangione S, Nasca TJ, Rattner S, Erdmann JB, Gonnella JS, et al. 'An empirical study of decline in empathy in medical school.' *Med Educ* 2004;38:934-41.

15. Hicks LK, Lin Y, Robertson DW, Robinson DL, Woodrow SI. 'Understanding the ethical dilemmas that shape medical students' ethical development: questionnaire survey and focus group study.' *BMJ* 2000;322:709-10.

16. Frank E, Carrera JS, Stratton T, Bickel J, Nora LM. 'Experiences of belittlement and harassment and their correlates among medical students in the United States: longitudinal survey.' *BMJ*;2006:333:68.