Professionalism is au courant in medicine today, but the movement to teach and evaluate professionalism presents a conundrum to medical educators. Its intent is laudable: to produce humanistic and virtuous physicians who will be better able to cope with and overcome the dehumanizing features of the health care system in the United States. However, its impact on medical education is likely to be small and misleading because current professionalism curricula focus on lists of rules and behaviors. While such curricula usually refer to virtues and personal qualities, these are peripheral because their impacts cannot be specifically assessed.

The author argues that today’s culture of medicine is hostile to altruism, compassion, integrity, fidelity, self-efficacy, and other traditional qualities. Hospital culture and the narratives that support it often embody a set of professional qualities that are diametrically opposed to virtues that are explicitly taught as constituting the “good” doctor. Young physicians experience internal conflict as they try to reconcile the explicit and covert curricula, and they often develop nonreflective professionalism. Additional courses on professionalism are unlikely to alter this process. Instead, the author proposes a more comprehensive approach to changing the culture of medical education to favor an approach he calls narrative-based professionalism and to address the tension between self-interest and altruism. This approach involves four specific catalysts: professionalism role-modeling, self-awareness, narrative competence, and community service.

require that educators measure the outcome of their efforts.\textsuperscript{12–17}

Why have we resurrected this explicit focus on “a distinctive professional virtue”? Let me present my own view of the forces that medical educators have been obliged to respond to, in order to meet their goal of producing highly competent and ethical professionals. Over the past several decades, medicine in the United States has evolved into a vast, increasingly expensive technological profit center, in which self-interest is all too easily conflated with altruism. While medical treatment became more efficacious than ever before, it also became potentially more harmful to patients. As technology advanced, patients developed higher expectations of cure, but at the same time they became progressively less satisfied with the personal aspects of medical care. While specialists spent more time wielding the mighty machine, they spent less time listening to or connecting with their patients. Meanwhile, commercialism began to run rampant in medicine, including the rapid development of for-profit hospital systems and managed care organizations and the appearance of a vast array of opportunities for physicians to make money from commercial relationships, especially with pharmaceutical companies. Commercialism set the stage for increasing conflict between the interests of physicians and their patients. The costs of the system skyrocketed, but it nonetheless remained inequitable and inaccessible to significant segments of the population. The evolution of applied science was not accompanied by the evolution of a legal right to health care. Yet our lingering cultural belief in equitable and relationship-based medicine haunts us and casts a pall over today’s machine-based medical practice.

As these problems developed, medical educators, far from ignoring them, responded with several generations of well-intended solutions that aimed to integrate the knowledge, skills, and attitudes of good doctoring into this new technological environment. Early innovations included creating the specialty of family medicine, formulating a so-called new paradigm for whole-person medicine (the biopsychosocial model), adding new skills to the curriculum (e.g., courses in communication, humanities, and biomedical ethics), and adopting more creative methods of teaching (e.g., problem-based learning). More recently, the evidence-based medicine movement has provided a means of cutting through the information-dense background to teach physicians to make more scientifically based clinical decisions, and, hence, to make patient care more beneficial. Still, the situation did not appreciably improve; while the minds of our students became sharper than ever, their hearts appeared to be listless, and their moral compasses adrift. At this juncture, educators adopted an entirely “new” tack, which in essence is a return to pre-1970s professional values; that is, they began insisting that professionalism itself be taught and evaluated.

In medicine, professionalism “requires the physician to serve the interests of the patient above his or her self-interest. Professionalism aspires to altruism, accountability, excellence, duty, service, honor, integrity and respect for others.”\textsuperscript{18, p. 5} This definition includes conduct (serving), aims (aspiring), and virtues or qualities (altruism, etc.). Note that these terms refer to different but intrinsically related aspects of human functioning. Ideally, conduct arises from aims, which, in turn, are conditioned by qualities. For young physicians to become more humane and effective healers, they must demonstrate professional conduct, which they are unlikely to do unless their education also explicitly nourishes motivation and virtue. My criticism of the professionalism movement is that, in the attempt to render professionalism more quantifiable, it may use skills and practices as surrogates for virtue. Becoming a physician involves witnessing, and not just behaving. To the extent that professionalism becomes a list of required practices, it is an example of H. L. Mencken’s neat and simple, but wrong, solution.

The State of the Art

The tradition of medical professionalism holds that there are deeply held values internal to the goals of the profession, a commitment to moral behavior grounded in “that which I hold most sacred” (to quote a contemporary version of the Hippocratic Oath), and, as a result of sharing these values and beliefs, a strong sense of community identity in medicine. Values, beliefs, and community are thus essential components of medical professionalism. But unless manifest in the lived experiences—the stories or narratives—of physicians, they are mere academic abstractions, like the bioethical principles of autonomy and beneficence. For medical professionalism to mold the behavior of physicians-in-training, it must be articulated as a meta-narrative that has developed over 2,500 years as a summation of, and reflection upon, many thousands of actual physicians’ stories from different times and cultures. Trainees must also experience professionalism as a bundle of contemporary narratives, either observed directly through role-model physicians and other health professionals, or indirectly through stories and film. In other words, to learn professionalism is to enter into a certain kind of narrative and make it one’s own.

I will use the term narrative-based professionalism to refer to this tradition, contrasting it with rule-based professionalism, which is the term I’ll use to describe the sets of objectives, competencies, and measurable behaviors that attempt to capture the concept of professionalism, but without focusing on its narrative ethos. I believe this dichotomy has heuristic value, although obviously neither “type” exists in pure form. My claim is that, given the current state of medical education, professionalism curricula are more likely to continue to move in the direction of lists of acceptable behaviors than to embody the full narrative tradition. To explain what I mean by this, let me describe briefly the texture of a medical trainee’s experience as it relates human values and professionalism.

Tacit versus Explicit Learning

Many observers have described a conflict between what we think we are teaching medical students and young physicians (the explicit, or formal, curriculum) and a second set of beliefs and values that they learn from other sources (the tacit, informal, or hidden curriculum).\textsuperscript{19–29} This conflict begins during students’ preclinical education and becomes more pronounced in the hospital and clinic. As students and house officers work their way through years of training, they gradually adopt the medical culture and its value system as their own. An
important aspect of this socialization is
the transfer, to trainees from their role
models, of a set of beliefs and values
regarding what it means to be a “good”
physician.

The explicit component of professional
development includes courses, classes,
rounds, advice, or other teaching
designed to instill professional values.
Tacit learning, by contrast, includes the
learning and socialization processes that
instill professional values and identity
without explicitly articulating those
issues. This hidden curriculum continues
throughout medical training. While the
explicit curriculum focuses on empathy,
communication, relief of suffering, trust,
fidelity, and pursuing the patient’s best
interest, in the hospital and clinic
environment these values are largely
pushed aside by the tacit learning of
objectivity, detachment, self-interest, and
distrust—of emotions, patients,
insurance companies, administrators,
and the state.

The Hospital Narratives

Culture consists of the matrix of stories,
symbols, beliefs, attitudes, and patterns of
behavior in which we find ourselves.
With this in mind, I want to propose a
mental experiment and ask the reader to
immerse her- or himself in a
contemporary teaching hospital. Once
there, listen to the conversations among
physicians and between physicians and
other health professionals. Pay close
attention to the texture of hospital
practice, in particular to its oral culture,
the stories that surround you. What sort
of stories are they? How can they be
categorized? Which of the narratives
appear to be especially meaningful to
their narrators and audiences? In what
ways do they fit together? What do these
stories teach about what it means to be a
good physician? In other words, in what
moral universe does clinical education
take place?

The first surprising observation you may
make is that the vitality of this universe is
centered outside the patient room. The
narrative world is most alive in the
teaching hospital’s hallways and
conference rooms and unit stations.
Generally, you discover that physicians
enter their patients’ rooms as
infrequently as possible; and when they
do enter, they listen to these patients as
little as possible. Instead, they usually
have an agenda in mind—a procedure to
perform or a parameter to check. Their
one-to-one interactions appear to play
only a small role in shaping the “received
wisdom” of hospital culture. In fact,
procedures performed on patients are
more frequently the starting place for the
stories doctors tell one another than are
their conversations with patients.

The second interesting feature is that
stories permeating the hospital ethos
don’t usually have patients as their active
protagonists. Rather, patients serve as
clever or frustrating or even stupid plot
deVICES—presenting obstacles or
challenges that may impair the story’s
progress or, alternatively, pleasing foils or
surprising twists that facilitate the story’s
successful resolution. Nonetheless, the
real protagonists or heroes of these stories
are usually doctors, although in an
increasing percentage of narratives the
doctors may play second fiddle to
cyborgs, i.e., machines of one sort or
another that figure things out and set
them straight.

With regard to villains, hospital
narratives are considerably more varied.
In some cases, the villain may be an
impersonal negative force—a virus or
accident, for example—which hardly
qualifies as a villain at all. But in more
complex cases, other health professionals
may play the role of villains; for instance,
the arrogant subspecialist, the power-
hungry surgeon, the incompetent nurse,
the stupid medical student, and so forth.
Moreover, the patient’s own family may
play a malevolent role, either as a result
of being present (e.g., the hostile,
questioning daughter) or being absent
(e.g., the son who never shows up).
Finally, patients themselves may take on
the role of Bad Guys, with scripts that
that demonstrate ignorance, anger, and—
above all—noncompliance. Nonetheless, the
stories are two-dimensional because they contain
little emotional resonance.

Yet the lack of emotional resonance in
patient-and-doctor stories does not
extend to interactions among students
and hospital staff. Most of the feelings in
medical culture that do get acknowledged
are those of doctors or other health
professionals, which tend to be expressed
in negative attitudes and outbursts: “This
place sucks!” “That gomer in 1215 is a
real pain in the ass.” “I’m so pissed off at
that resident I could scream.” Although
expressions like these are permissible, the
physician ethos in general disapproves of
emotion and favors stoic acceptance.
This, in fact, is one way that doctors
demonstrate the superiority they feel over
patients, who are often emotional and let
subjective perspectives get the best of
them.

Finally, as should be obvious, the virtues
and values articulated in this thumbnail
sketch of hospital culture bear little
relationship to the traditional ethos and
morality of medicine. If you accept this
culture, you say self-interest whereas I say
altruism. You say the patient is an object
of interest; I say the patient is a subject of
respect. You say the bottom line is to free
up the bed; I say the goal is to promote
healing.

This glimpse that I’m presenting of the
world in which medical students and
young physicians find themselves is a
gross overgeneralization. First, it ignores
the narratives of nursing, social work,
chaplaincy, and many other professions.
These professions, of course, overlap,
reverberate with, and influence one
another but—and this is quite
remarkable—they seem to influence the
culture of medicine very little. While
physicians in the hospital are completely
dependent on multiple other
professionals and support personnel, the
culture of medicine itself remains rather
isolated and uninfluenced by them.
Second, nowadays a substantial
proportion of medical education takes
place in clinic and office settings, where
patient narratives may play a larger role
in trainees’ overall experiences. Finally,
I’ve overgeneralized about physicians
themselves. Fortunately, patients and their physicians also tell vibrant and edifying stories, and many residents and students repeat them and learn from them. Hospital culture is by no means entirely hostile, and many trainees graduate from it having cultivated positive and caring professional identities.

The Varieties of Professionalism

However, the generalizations and value conflicts I have described do exist and do affect the outcomes of medical education. Peter Williams and I have argued elsewhere that such conflict between tacit and explicit values seriously distorts medical professionalism.26–28 At an experiential level, medical students and house officers relieve or resolve their internal conflict by adopting one of three styles of professional identity.

- A technical professional identity, in which young physicians abandon traditional values and adopt a view of medical practice consistent with hospital culture. They become cynical about duty, fidelity, confidentiality, and integrity; and question their own motivation and that of others, thereby narrowing their sphere of responsibility to the technical arena.

- A nonreflective professional identity, in which physicians consciously adhere to traditional medical values while unconsciously basing their behavior, or some of it, on opposing values. In this type of self-delusion, a young physician believes that when she acts in accordance with hospital culture, she actually manifests the explicit values she learned in the classroom, although instead it is the hidden, negative values that are being expressed. For example, compassion is best manifested by detachment, and personal interaction is suspect because it lacks objectivity.

- A compassionate and responsive professional identity, adopted by a third, substantial group of young physicians, who thereby overcome the conflict between tacit and explicit socialization.

Let me emphasize that these characterizations represent the physician’s internalization of what being a good doctor means and the manner in which he or she should behave. As such, they cut across my rule-based and narrative-based categories, which refer to the manner in which professionalism is conceptualized and taught by medical educators. Williams and I claim that a large percentage of our graduates are best characterized as nonreflective professionals; that is, physicians who believe that they embody virtues like fidelity, self-effacement, integrity, compassion, and so forth, while acting in ways that not only conflict with these virtues, but also contribute to contemporary problems in health care such as rising costs, inadequate physician–patient communication, and widespread dissatisfaction. It is this group of physicians that most clearly exemplifies Albert Jonsen’s insight about the core dynamic of professionalism, “The central paradox in medicine is the tension between self-interest and altruism.”30, p. 7

A Flag in the Wind

Thomas Inui’s report, “A Flag in the Wind: Educating for Professionalism in Medicine,” which is based on his experience as scholar-in-residence at the AAMC,31 presents a systematic and comprehensive analysis of our continued failure to instill professional virtue in medical education. Because Inui’s eight conclusions parallel my argument, I want to summarize them here. First, “the major elements of what most of us in medicine mean by professionalism have been described well, not once but many times.”31, p. 4 This is understandable because these elements are based upon “the attributes of a virtuous person,” about which there is widespread consensus. Next he observes, however, that the literature and rhetoric of medicine fail to grasp “the gap between these widely recognized manifestations of virtue in action and what we actually do” in medical education and practice.31, p. 4

Inui acknowledges that physicians “may be unconscious of some of this gap” but when they are conscious of it, they tend to be “silent or inarticulate about the dissonance.”31, p. 4

In his fifth conclusion, Inui draws attention to the discrepancy between “what they see us do” (the hidden curriculum) and “what they hear us say” (the formal curriculum). Under these circumstances, “students become cynical about the profession of medicine—indeed, they may see cynicism as intrinsic to medicine.”31, p. 5 In this context, “additional courses on medical professionalism are unlikely to fundamentally alter this regrettable circumstance. Instead, we will actually have to change our behaviors, our institutions, and ourselves.”31, p. 5 Finally, Inui indicates that the most difficult challenge of all is for students and educators to understand that medical education is “a special form of personal and professional formation” (emphasis added), rather than a species of technical learning.31, p. 5

Inui recognizes that the gap between belief and behavior that characterizes our teaching hospitals is partly unconscious. To the extent that this is true, these physicians manifest nonreflective professionalism; that is, in the formation of their professional identities, they have internalized the belief that certain nonvirtuous behaviors are virtuous, since they are “the way things are in medicine.” The term “nonreflective” implies that these physicians rarely, if ever, step back and consider the impact of their behavior on themselves and others, as human beings deserving of care and respect. Inui suggests that another part of the institutional gap between belief and practice is conscious and, therefore, hypocritical. Unfortunately, physicians with little interest in the narrative and value dimensions of medicine may at times be required to serve as teachers—and presumably role models—because of the infrastructure and demands of medical education. When these physicians impart their rote “wisdom,” they do so hypocritically. Trainees quickly detect this and respond with cynicism.

Narrative-Based Professionalism

To nurture the professional virtue, or narrative-based professionalism, that I am advocating, Inui observes that “we will actually have to change our behaviors, our institutions, and our selves.”31, p. 5 In the educational culture that I’ve described, the prospects for such change seem bleak; yet I believe that cultural change is possible, given the right catalyst and sufficient receptivity in the medical community. I believe that receptivity among medical educators is growing, given their dissatisfaction with the processes and products of
professionalism education. As to the right catalyst, I will suggest four interrelated educational requirements that could provide a basis for the formation of a new medical morality in the 21st century. In proposing this framework, I am drawing upon the ideas of others, especially my colleagues in the fields of reflective practice and narrative medicine, whom I cite below. Moreover, as a means of evaluating a trainee’s performance as he or she progresses through the process of learning professional virtue, I proposed another borrowed idea, the educational portfolio.32–35 Such a portfolio is a collection of material assembled over time that provides evidence of learning and achievement. A medical trainee’s portfolio might be structured to address specific competencies and include, for example, formal papers, case reports, extended patient narratives, descriptions of critical incidents, reflective writing, and self-assessment.36

Professionalism role-modeling

The first requirement for a sea change in professionalism is to increase dramatically the number of physicians who are able to role-model professional virtue at every stage of medical education. By this I mean full-time faculty members who exemplify virtue in their interactions with patients, staff, trainees, and the community at large; who have internalized a broad, humanistic, and narrative perspective; and who are willing to forego high income in order to teach. These physicians eschew commercial entanglements. Because such physicians are reflective, as opposed to nonreflective, in their professionalism, their presence would dilute and diminish the conflict between tacit and explicit values, especially in the hospital and clinic. Such physicians communicate honestly and directly with trainees, who are likely to “get” the message because it comes from the heart. With the incorporation of more such faculty, the teaching environment would contain fewer mixed messages, where, for example, the voice says “engage” while the behavior says “detach.” What trainees need is time and humanism. However, such faculty members cannot pay for themselves, and this implies major new financing for medical education.

Self-awareness

The second prerequisite for developing narrative-based professionalism is to provide, throughout medical school and residency, a safe venue for students and residents to share their experiences and enhance their personal awareness. Doctors need to understand their own beliefs, feelings, attitudes, and response patterns. One of the earliest proponents of this view was the British psychiatrist Michael Balint, who encouraged physicians to meet regularly in small groups to discuss difficulties with patients and their personal reactions to practice.37 Physicians tend to view emotions as negative or disruptive, and often confuse intellectualizing their responses (naming an “affect”) with genuine emotion.38 Physicians are particularly vulnerable to anxiety, loneliness, frustration, anger, depression, and helplessness when caring for chronically or terminally ill patients.39 They often try to cope with these emotions by suppressing or rationalizing them. The more effectively physicians reverse this process by developing self-awareness, the more likely they will have the resources to connect with, and respond to, their patients’ experiences.

In addition, the trainee’s moral development may be hindered by everyday learning situations. These include conflicts between the requirements of medical education and those of good patient care, assignments that entail responsibility exceeding the student’s capabilities, and personal involvement in substandard care. Once again, the opportunity to discuss, analyze, critique, and sometimes repair these situations allows students to find their own voice and may eventually empower them to develop that voice effectively.40–43

Narrative competence

Medical practice is structured around narrative—between physician and patient, teacher and student, and the like. However, as a result of the tension between explicit and tacit values, students learn to objectify their patients and devalue subjectivity. In part, they learn to conceptualize their patients in terms of flow sheets, rather than personal stories. At the same time, they internalize hospital narratives, which tend to be cynical, arrogant, egotistic, self-congratulatory, and highly rationalized, but nonetheless become influential in the formation of the trainee’s professional persona. Moreover, students immersed in these stories have little time to listen to, and may also lack the skill to understand and respond to, their patients’ stories, or to experience themselves as characters in the larger narrative of professionalism in medicine.

Accordingly, the third prerequisite for fostering narrative-based professionalism is the development of narrative competence. This can be understood as “the ability to acknowledge, absorb, interpret, and act on the stories and plights of others.”44 The narrative medicine movement provides a way of reframing the knowledge, skills, and attitudes of good doctoring under the aegis of language, symbol, story, and the cultural construction of illness.45–50 It draws upon the centrality of clinical empathy in establishing and maintaining therapeutic relationships, and also upon the broader, more imaginative empathy that allows observers to “connect with” the experience of persons not immediately known to them, such as the uninsured in Appalachia, HIV-infected children in South Africa, or refugees in Sudan.51–55

The trainee’s own life experience, molded by positive role-modeling and reflective practice, serves as the basic material from which narrative competence may develop. However, students may enhance their repertoires of life experience by exposure to the written, filmed, and oral narratives of real and fictional physicians; and they may increase awareness of their own developing professional identities by writing personal and professional narratives consistently and with discipline.56–61

Community service

Finally, in order to teach narrative-based professionalism, the medical curriculum must include socially relevant service-oriented learning. Interaction with patients in the hospital or office setting is insufficient to provide students and young physicians with narratives of interdisciplinary practice, biopsychosocial modeling, and social responsibility. The American Medical Association’s Code of Ethics specifies in section VII that “A physician shall recognize a responsibility to participate in activities contributing to an improved community.”62 In section III, the Code of Ethics indicates that “A physician shall . . . recognize a responsibility to seek changes in (legal) requirements which are contrary to the best interests of the patient.”62 These manifestations of
professional virtue need to be addressed in medical education.

Service learning may operate on many different geographic and social levels, from activities that take place locally to those on a national or international level. Moreover, the focus may include students contributing to clinical care (e.g., working at free clinics, doing clinical work in third-world countries), public health work (e.g., vaccinating migrant workers, assisting in “Stop Smoking” campaigns), health education (e.g., participating in HIV education in local high schools, speaking at church groups and community organizations), community service (e.g., volunteering in local agencies or with groups that provide direct assistance to third-world countries), and political action on health and welfare issues. Whatever the specific tasks involved, the minimal required “dose” of community service must be sufficiently large for students to view it as integral to the culture of medical education, rather than an unconnected add-on.

Conclusions

Professionalism is an awkward in medicine today, but the movement to teach and evaluate professionalism presents medical educators with somewhat of a conundrum. Its intent is laudable: to produce humanistic and virtuous physicians who will be better able to cope with and overcome the dehumanizing features of the health care system in the United States. However, the impact of this movement on medical education is likely to be small and misleading unless it directly confronts the “central paradox in medicine,” which is the “tension between self-interest and altruism.”

In many ways, today’s culture of medicine tends to be hostile toward altruism, compassion, integrity, fidelity, self-effacement, and other traditional qualities. In fact, hospital culture, and the narratives that support it, implicitly identify a very different set of professional qualities as “good,” and sometimes these qualities are diametrically opposed to the virtues that we explicitly teach. Students and young physicians experience internal conflict as they try to reconcile the explicit and covert or hidden curricula, and in the process of their professional character formation they often develop nonreflective professionalism. Additional exercises in or courses on professionalism as it is currently taught are, in themselves, unlikely to alter this dynamic, even if they are supplemented by lists of competencies that trainees are required to demonstrate. This rule-based approach to professionalism does not alter the tension or conflict between tacit and explicit values.

Instead, I propose promoting narrative-based professionalism as a more comprehensive approach to changing the culture of medical education and addressing its central paradox. This involves immersing students and young physicians in a wide array of narratives, drawn from their own experiences as well as those of others, that display professional virtue. In essence, this approach would provide a counterculture of virtuous practice that may gradually displace the more negative elements of contemporary medical culture and allow students to bear witness to their profession, not just symbolically through oaths and White Coat ceremonies, but in the ways they conduct themselves in their day-to-day practice. Each component of this approach—professionalism role-modeling, self-awareness, narrative competence, and community service—overlaps with and reinforces the others. Moreover, each lends itself to longitudinal evaluative processes, such as the creation of narrative-based professionalism portfolios by students and residents.

Many of the elements for this development are already present, but in most medical schools dispersed too thinly and/or integrated too sparsely to produce a significant impact on the culture of medical education. I don’t know what critical mass might be required to initiate a chain reaction in medical education in favor of narrative-based professionalism. Presumably, however, it would not require that every faculty member and attending physician pass a litmus test for virtue and empathy. Nor would it mandate that commercialism disappear. The concept of a catalyst is important here because I believe that cultural change can take place if a relatively small number of well-placed faculty members, curricula, faculty development programs, and institutional supports are brought together with an aggressive treatment plan not only to alleviate the symptoms of an ailing professional culture, but also to set that culture on the road to recovery.

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