Teaching and Learning of Professionalism in Medical Schools

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Abstract

Concerns about professionalism in medicine have made necessary the explicit teaching and learning of ethics, professionalism and personal development. The noble profession of medicine, taken up as a "calling" by those who are expected to put the needs of the patient above their own, appears to have become a fees-for-service business model and trade. Parental expectations, the diminishing sense of responsibility in teachers, lack of role models, technological advancements, sub-specialisation and third-party involvement in the healthcare delivery system have been identified as reasons for these concerns. The General Medical Council in the United Kingdom, and other professional bodies in both Europe and the Americas, have emphasised the need to enhance the teaching and learning of professionalism in medical schools, particularly the development of good attitudes, appropriate and competent skills, and the inculcation of a value system that reflects the tenets of professionalism in medicine. The medical curriculum will need to be scrutinised so as to introduce the subject of professionalism at all levels of training and education. Barriers to learning professionalism have been identified and students need to be equipped to resolve conflicts and to put the needs of others above their own.

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Introduction

There is now worldwide consensus that the elements of medical professionalism need to be enhanced and explicitly taught in medical schools. Medical schools in the United Kingdom (UK) have recently published a model for a core ethics curriculum.[1-3]

Historical reference to the medical professional as a healer has evolved into the doctor playing the role of a biomedical scientist and charging fees for service. Professionalism in medicine has traditionally been seen as an enactment of values and ideals for physicians in serving individuals and populations, prioritising the interests of those they serve above their own. With several global and external factors influencing the profession and the professionals, there has been an apparent erosion of sustenance of the tenets of medical professionalism. Medical curricula are being scrutinised so as to introduce a system of checks and balances to maintain high levels of professional behaviour and values amidst changing perceptions and altered health delivery systems. To some extent, changes in individual value systems, third-party involvement in medical care and the extensive use of technology have influenced decision-making in medicine.

Rationale for Making the Teaching and Learning of Professionalism Explicit

Osler[4] emphasised that the traditional learning method, where the student, working in clinics and wards under the close supervision of full-time faculty, was an effective master-apprentice model in inculcating the elements of professionalism.

Many factors today appear to be threatening professionalism in medicine, including the slow disintegration of the medical community. In the UK, *Tomorrow's Doctors*[5] was first published by the General Medical Council in 1993, signalling a significant change in the learning process in medical education.

Good Medical Practice[6] (published in May 2001 in the

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UK) outlines the principles of professional practice, clearly explaining to the public the standards of practice and care they should expect. The main recommendations made in the revised edition of *Tomorrow's Doctors* (2001) address attitudes and behaviour that must be developed by doctors that would be appropriate to future responsibilities to patients, colleagues and society in general.

Some of the reasons the teaching and learning of professionalism need to be explicit, rather than remain a "hidden curriculum",[7] include:

1. The present system of admitting candidates based on academic excellence alone may have little relation to the attitude and aptitude of the student with regard to the profession.
2. Medical education is seen as a business, a career and not a noble trade and a "calling".
3. Managed care in many countries, including Malaysia, has been implicated as an impediment to creating a learning environment. The introduction of health insurance by third parties with stipulations and guidelines may curtail the delivery of decisions based on health needs.
4. The introduction of medical technology without impact studies on national economy and cost-benefit ratios has contributed to excessive investigations before eliciting an adequate history and performing a thorough physical examination, which negate the need for some of these investigations. The latter procedures form important components of medicine that create astuteness and harmonious doctor-patient relationships.
5. Categorising patients within a class system distinctly diminishes encounters with senior clinicians in many developing countries, together with a loss of supervision and a lack of mentoring (a vital link in the teaching-learning environment), leads to a potential lowering of the standard of professional conduct. One study on medical errors revealed that when a mistake is made, only 24% of attending doctors notified the family and 55% told their supervisors.[8]
6. The reward system in teaching institutions, where emphasis is placed on publications and presentations, rather than ethics and professionalism, has an impact on the learning of professionalism.

The Task at Hand

It has often been said that patients and the community should remain the main focus of the profession. Patients desire interpersonal relationships, humaneness, time for care, skills and competence in attending doctors. They want to be involved in decision-making. In communities where health needs and medical knowledge are poor, especially among the lower socio-economic groups, junior doctors may take a paternalistic approach to patient care. Such a strategy is neither suave nor professional as it simply reflects deficiencies in communication and counselling skills.

Medical schools should continue to emphasise the need for improvements in communication skills and in the inculcation of the value system. Patient safety is being increasingly emphasised through expected standards of medical practice. The GMC has reiterated the need for a reduction in factual overload in the medical curriculum and to put more emphasis on teaching skills in effective communication. There is now more focus on preparing the pre-registration house-officer to acquire both medical and communication skills through learning and shadowing senior members of the profession.

The International Medical University (IMU) runs a unique curriculum where final-year students spend the last 6 months of training in a district general hospital doing a senior clerkship, with a need to develop portfolios on clinical experience acquired throughout the period of study. This component of the training allows for a closer supervisor-student relationship and better opportunities for self-reflection and remedial action. The positive values of this system are seen at the exit viva that the candidates take prior to graduation. One of the 8 domains of the IMU medical curriculum is the development of good work ethics and the acquisition of the tenets of medical professionalism. The impact of the learning activities is evaluated through students' reflections both at the exit viva through portfolio writing and in the Community-Family Case Studies (CFCS), which are carried out through the clinical years.

Internalising the Tenets of Medical Ethics and Professionalism

Problem-based learning (PBL) and clinical skills laboratory (CSL) training, two important teaching-learning activities in the IMU curriculum in the first 5 semesters, provide ample opportunities for teachers to inculcate professionalism and ethics. This is further enhanced during task-based learning and clinical ward teaching. Elements of professionalism can be introduced in a sequential manner so as to have a spiralling effect as the student progresses through the pre-clinical to the clinical years. Attempts should be continuously made to internalise the tightly woven elements of professionalism and humaneness. A lack of explicit attention to humanistic values will invariably lead to a neglect of such values. Medical education must take cognizance of this.

Students are repeatedly bombarded with traditional case write-ups in the clinical setting. The IMU is experimenting with two alternative interventions in the clinical years,

where students are rotated through various disciplines of medicine. Students will be encouraged to write personal reflections (one a positive and another a negative encounter in 300 words) on aspects of professionalism in the clinical setting in place of a few of the required case write-ups. In the portfolio development in CFCS, students are encouraged to comment on the application of professionalism and human values. It appears timely to reiterate that medical educationist should not reduce humans to the smallest parts of their bodies, more commonly seen as medical intervention, as medical technology gives way to holistic care of the patient (who should remain a member of the healthy community, temporarily impoverished in medical knowledge and impaired with disease/disorder). There must be constraints on putting the patient through a battery of tests to meet the requirements of the physician sub-specialist, the lure of the medical industry and the fear of litigation.

During feedback from medical students on the impact of the education process in medicine, a 4th-year medical student wrote on the importance of adhering to the ethical code of practice and to incorporate a sense of responsibility and public service. She valued the teaching of core human values and the necessity of responding to societal needs. She also wanted mentors to teach her how to handle internal conflicts and barriers to professionalism, without compromising her career and livelihood.[9]

Barriers and Obstacles to Professionalism in Medicine

The need for faculty members and mentors to understand the philosophy of professionalism is all the more wanting now as more medical schools concern themselves with medical education. Teachers need to understand the objectives in developing professionalism and inculcating this in the students under their care from the formative years. Clear objectives with the development of a core curriculum are essential. Sensitising faculty members to this through workshops and introducing teaching methods during PBL and CSL training can be effective.

Students in the pre-clinical years may not be exposed to the role models who can have an impact on the moulding process and this needs to be remedied before conflicts arise in the minds of students as they plough through core contents so very familiar in pre-clinical years.

It is common knowledge that students enter medical school with pre-conceived concepts of learning from practitioners of the medical discipline and may be perplexed at having to spend half of their early educational years with non-medical practitioners, learning the foundations of medicine through basic science teaching. If appropriate role models appear early during this period and opportunities are given for early exposure to the clinical setting, remedial measures may be put in place.

Parents' desire for their children to acquire skills in medicine quickly, so as to reap the rewards after graduation places the student in a dilemma, and appreciating professionalism in medicine may be difficult for them. Teachers will need skills to help student overcome such conflicts, so that the latter will not view the profession as an investment-business model. Medical education is expensive and such expectations are fraught with disdain. Medical educationists can help by not compromising the value system in medicine.

Developing the Curriculum

Curriculum development for professionalism can be daunting, but core values need to be delivered explicitly throughout the medical education, reflecting, reinforcing and reiterating as more complex subjects are introduced along the educational process. Consensus in the development of the core curriculum is essential and leaders on the subject can influence regulatory bodies in developing the core curriculum.[10]

Internalising the core curriculum within the existing teaching-learning activities will be less threatening and may preclude an increase in workload and core content. This is best done by reviewing the curriculum, including matters related to professionalism. It is common knowledge that the ideals of medicine taught will change as the student matures through the education process, with an element of cynicism if mentors fail to practise what they preach. Here again, strong external influences, personal needs, material wants and family pressure need to be contended with. All these issues will impact on the behaviour and attitude of the student and mentors can assist in the coping mechanism. This is indeed an uphill task for educators and faculty members.

The Discipline of Professional and Personal Development

The discipline of Professional and Personal Development (PPD) is not new but may not be seen as such by faculty members. Therein lies the need for leadership and the recognition of the discipline as a distinct entity within the medical education process. In the long run it could develop into a Faculty of Medical Ethics and Law with dedicated staff and participating membership from all disciplines of medicine. Its tasks may include promoting, collaborating on, and developing the curriculum and resources related to PPD. The initial approaches to sensitising faculty and winning over policy makers will enable the charting and implementation of certain strategies.

The core curriculum could include the following with regard to knowledge, skills and attitude:

1. *Knowledge*
   - Basic concepts of ethics to be introduced in PBL and Clinical Skills Lab.
   - Ethical concepts and professional ethics in the clinical setting to be enhanced through existing activities (portfolios, reflections of encounters, justice in health, terminal illness).
   - In later clinical years, ethics rounds and cost containment to be introduced as the students understands the implications of the health delivery system.
2. *Skills*
   - The skills of problem solving, clinical reasoning and critical thinking are learned again through existing teaching-learning activities.
   - Medicine is a lifelong learning process – inculcation of this value will go a long way in achieving the objectives of the exercise.
   - Moral reasoning skills and ethical practices will equip the student to communicate such issues to patient and family.
   - Time and again the clinical students find themselves not being able to disseminate information because of the hierarchical system. There may be instances when transference takes place as they involve themselves in the management of patients. Herein lays the importance of employing ethical principles in resolving such problems. Students need to be able to cope with practices which may be contrary to taught principles. Mentors will play eventful roles under such situations.
3. *Attitude*
   - The need to promote humanistic values and to detest dehumanising processes is vital.
   - Teaching good medical practice, and inculcating the values and behaviour expected by society, and sensitivity to religion and culture are needed, especially when students may have been monolithic in their exposure to different cultures in Malaysia because of their early education.
   - Role modelling by teachers has a positive impact on the attitudes and behaviour of students.

Although the conceptual and theoretical knowledge of ethics and professionalism can be introduced through lectures, seminars, reading and computer-assisted instruction, it is fundamentally discursive. Small-group learning in PBL, the Clinical Skills Lab and teaching in the clinical ward using case studies and problem-solving exercises could be used to exemplify and extend didactic teaching methods. Formal ethics rounds, involvement in audit meetings, and peer reviews can have crucial influences on attitudes and behaviour. Case studies created for discussion could involve the care of the dying, racism, reluctance to serve the marginalised, adapting to stress and burnt out states.[11-13]

Interdisciplinary approaches can make the teaching of medical ethics relevant and educational as faculty members from different disciplines come together to address common issues. This will allow for better faculty involvement and the development of a more integrated curriculum. Real-life encounters make suitable templates on which one can build for case analysis.

Assessment and Evaluation

Monitoring the implementation of PPD will have an impact on the success of the programme. Once the core curriculum has been set and the intervention phases slotted within the existing curriculum, section heads can monitor PPD activities through tools already available. The views of some are that it would be a positive sign once students acknowledge the importance of ethics in their activities.[12]

Clearly there is no single method for assessing knowledge and skills. In IMU, some of the evaluation tools being used have been mentioned above. Written case reports with dedicated approaches to ethical and professional issues are relevant. Self-reflections on both positive and negative encounters have been referred to. These encounters, especially if they are negative in nature, need to be addressed by facilitators so that they are resolved within the context of the education process. The PBL classes and group seminars can be usefully employed not only to test clinical aspects of professionalism but also those related to accountability, responsibility, caring attitudes and sharing approaches. Self and peer reviews may be useful tools in this aspect. Portfolios, tutor assessments and feedback from both simulated and real patients can be useful tools. The assistance of medical educators should be sought to develop valid, effective and relevant tools that can be easily implemented without exhaustive analysis.

Conclusion

There is general consensus that professionalism in medicine should no longer remain a hidden curriculum but be enhanced and taught in an explicit way in view of the changing trends in medical care and the barriers to professionalism. The development of a core curriculum should be weaved into the existing medical curriculum without increasing the workload. Training faculty members on the teaching and learning of professionalism in medicine will be a desired activity in medical schools. The ultimate aim would be to produce caring doctors with an in-built value system.

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