Mapping, Modeling, and Mentoring: Charting a Course for Professionalism in Graduate Medical Education

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Introduction

Professionalism, like common sense, remains a timeless ingredient in the ethically successful practice of medicine in the twenty-first century. Professional ideals are particularly relevant in times of economic and social upheaval, medicolegal crises, provider shortages, and global threats to the public health.[1–4] The American Board of Internal Medicine specifies professionalism as "constituting those attitudes and behaviors that serve to maintain patient interest above physician self-interest."[5] Because of its transcendent nature, professionalism, like ethics, is also considered "a structurally stabilizing, morally protective force in society."[6] Professions enjoy tremendous deference and autonomy in exchange for three unwritten but prerequisite promises: expert knowledge, self-regulation, and a fiduciary responsibility to place the needs of the client ahead of self-interest.[7] Many educators suggest that professionalism includes additional characteristics such as honesty, altruism, temperance, commitment, integrity, and suspension of self-interest.[8–16] However, there are large gaps in providing more user-friendly and operational models of professionalism to learners and evaluators at all levels of the academic hierarchy.[17–23]

Professionalism: A Core Mandate

Professionalism has been championed by the Accreditation Council for Graduate Medical Education (ACGME) in hopes of improving the quality and, ultimately, the outcomes of graduate medical education. As one of the six core competencies identified and endorsed by the ACGME Outcome Project Advisory Committee, professionalism enjoys significant overlap with the other five core foci: patient care, medical knowledge, systems-based practice, practice-based learning and improvement, and interpersonal and communications skills. Although residency-training programs are now being held accountable for the new core competency requirements, there are few established criteria or objective standards for implementation and outcome assessments. One way to begin to address this programmatic gap is to define the parameters of both professional and unprofessional behavior.

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Mapping Professionalism in Action: Beyond Cardinal Virtues and Deadly Sins

> *Our character is what we do when we think no one is looking . . .*
>
> H. Jackson Browne

Penultimate assessments of professionalism are often conducted retrospectively by aggrieved families, risk managers, and attorneys.[24] To apply the principles of forward thinking proactively to professional development, there is an immediate need to be more explicit in defining what is clearly in or out of bounds. Nazis argued at Nuremberg, for example, that there were no rules against the evils perpetrated by the Reich's physicians, and subsequently, new rules had to be written while the Green Commission was still in session. A preemptive fostering of professional virtue and eradication of vice is a preventive combination strategy that may keep Tuskeegee, Willowbrook, and Nuremberg from ever being repeated.

Virtue-driven aspirations, ideals, and relative goals provide the roadmap to good practice, but to be relied on, they must be developed with practice, repetition, and encouragement. Virtue promotion may be thought of as a kind of moral vaccination against the ethical pitfalls inherent in modern medical practice. Many virtues are called on to be a consummate professional: prudence, nonjudgment, self-effacement, compassion, trustworthiness, resilience, communication, friendliness, humility, intelligence, vigilance, and tact, just to name a few.

Resisting vice is also important, however, and has received little attention in medical education to date. Many of the original seven deadly sins still apply: avarice, pride, sloth, and lust have no place in professional medical practice. To this list one might well add apathy, disrespect, recklessness, insensitivity, and dishonesty. Nurturing virtue and opposing vice is one way to develop useful and skilled physicians that measurably improve the quality of care for patients, enrich the environment and relationships in which they work, and bring honor and integrity to the forefront of the healing arts.

Although optimizing the quotient of virtue over vice in the profession is laudable, we must ensure that professionalism is a practical construct in everyday medical education and practice. Even as the ACGME counsels that the ideal professional "demonstrates compassion" in his or her interactions with staff, patients, and families, this notion of demonstrating compassion is a vague and intangible objective that is nearly impossible to quantify, even though we often "know it when we see it." To better operationalize "professionalism," high-minded ethical principles such as nonmaleficence and Aristotelian virtues of temperance and phronesis must give way to more concrete notions of professionalism: punctuality, accurate charting, grooming, truth-telling, and sexual abstinence in the workplace, to name but a few. It is in these straightforward examples of actual behaviors, and not merely by the lofty underlying aspirations, that an authentic conception of professionalism comes to life.

Missing Guideposts in Professional Education

Absent from most medical curricula are behavioral norms and standards of professional conduct, because most educators take these guidelines completely

for granted. However, all GME programs expect their interns to follow these norms at the outset of training and to behave in ways that are becoming to both the program and the profession for years to come. Learning objectives and outcome measures for professionalism must be explicit, as they are for cognitive and procedural skills.[25] Moreover, as part of both contingency planning and continuous quality improvement, remediation strategies for lapses in professionalism should also be planned a priori. Unacceptable behaviors and their paired consequences should be clearly articulated and transparent to residents from the very beginning of residency, so that there can be no doubt as to the grounds for advancement, remediation, or dismissal. Otherwise, it would be unfair and inconsistent to expect a resident to comply with secret rules or laws that remain largely unwritten.

Early and consistent exposure to the rules of professionalism will also serve to orient the young resident toward the importance of integrity, honesty, and trustworthiness throughout residency and beyond. Although adding specific performance criteria to the curricular demands of a program may seem tedious, it is a one-time fixed cost that may avoid later misunderstandings and expenditures on remediation, counseling, or litigation downstream.[26]

Judging Professionalism: A Framework for Evaluation and Remediation

> *Without basic codes of conduct and decency, organized medicine could not exist.*
> Dr. Bob Baker, speech at the 150th anniversary
> of the AMA Code of Ethics, 1997

As in Dante's circles of *Paradiso* and *Inferno*, there are tiers of professional and unprofessional behavior that are more or less virtuous or vicious, respectively. One simple candidate, four-tiered schema of behavioral professionalism can include two levels of professionally "good" behaviors, and two levels of unprofessional or "bad" behaviors (see Table 1). Within these four strata it may be relatively easy to distinguish more virtuous or model behaviors from those activities and actions that are merely expected or basic to professional practice. Similarly, simple *venial* mistakes or lapses in professionalism may be distinguished from those egregiously unprofessional behaviors that warrant serious remediation or dismissal.

Each of the four groupings or categories may be assigned a valence or score for each of the items within that category. These can be summed and weighted and used in semiannual assessments of performance. Such valences can promote a forum for discussion of more formative professional evaluation as well as a platform on which discussions of remediation may be predicated.

Due to the multiplicative influence of faculty, professionalism among the teachers should also be evaluated and addressed with the same attention and fervor given to residents and students. At a minimum, 360-degree evaluations for attending physicians and residents should involve nursing, other faculty, staff, students, administrative, and office personnel as part of the faculty and resident development process. Residents should be formally evaluated at least every 6 months in all essential areas of training, and appropriate documentation of evaluations should be kept in the permanent records. Evaluations may include descriptive evaluations, which can be very effective in assessing less

Table 1. Virtues and vices in professional practice: The four valences of professional behavior: ideal(+2), desired(+1), unacceptable(−1), and egregious (−2)

Professional

Aspirational/ideal behaviors (+2)
- Generous and forgiving toward coworkers, consultants, patients, and families
- Altruism toward others
- Resiliently positive attitude and good humor
- Generate goodwill in others
- Humility regarding own achievements
- Nurturing of learners and solicitous of questions
- Charity toward patients, staff, and consultants
- Consistently goes beyond the call of duty
- Defuse volatile and anxious patients and staff
- Role model inside and outside the workplace
- Do the right thing for morally praiseworthy reasons

Desired/expected behaviors (+1)
- Arrive on time and prepared for work
- Act in the patient's interests
- Complete medical records
- Complete care and disposition of patients before signing them out
- Protect patient's interests and confidentiality
- Treat patients, family, staff, and paraprofessional personnel with respect
- Protect staff, family, and patients
- Teach other team members (students, staff, residents)
- Discuss difficult issues (treatment options, end-of-life decisions, diagnoses) with compassion with patients, family, and staff
- Openly accept criticism from faculty and staff

Unprofessional

Unacceptable behaviors (−1)
- Arrive late or unprepared for work
- Expose patient information
- Incontinence of expletives or other offensive language or information
- Accept significant gifts from sponsors or drug companies
- Perform nonemergency procedures without appropriate consent
- Make passes at students or patients
- Discriminate among students or patients on the basis of race, gender, creed, or other objective characteristics
- Interact disrespectfully with patients, family, or staff
- Failure to appropriately attribute other's work when using it for education or research
- Failure to execute or respond appropriately to faculty direction or instruction

Egregious behaviors (−2)
- Abandon patients
- Refractory lying, cheating, or stealing
- Substance abuse or dependence
- Failure to learn from past mistakes
- View or disseminate pornography or other offensive material at workplace
- Take risks that seriously threaten safety of patients and staff
- Harass students, patients, or staff
- Verbally or physically assault patients, family, or staff
- Falsify medical records or research data

technical aspects of medical training.[27] Additionally, feedback relating to specific situations or encounters should be given by faculty mentors on an individual level. As mentioned, ancillary staff and peers may also play an important role in providing feedback. When possible, objective measures should be utilized, such as integration of professional or ethical issues into oral Board examinations or on annual training examinations.

Modeling: Practicing What We Preach

> *"One preaches well who lives well," said Sancho, "and that's all the divinity I can understand."*
> Miguel de Cervantes, *Don Quixote*

Ensuring that faculty also properly model, guard, nurture and evaluate professionalism demands considerable investment. Teaching faculty carry a tremendous responsibility to guide resident and student charges on related matters of ethics, professionalism, interpersonal skills, and multicultural competency. Faculty may be required to learn new skills to be able to effectively teach in an outcomes-based paradigm, given that issues related to professionalism cannot be effectively taught in the classroom alone. These types of behavioral topics must be addressed "real-time" by models and mentors in the clinical, academic, research, and administrative settings.

Inside or outside the hospital, actions always speak louder than words, and thus modeling is a very powerful way to impart to residents the importance of professional behavior. The actions of our opinion leaders and teaching faculty are certainly more instructive to students learning humanistic skills than all the books and learned journals of an entire medical library.

Modeling itself is an ancient behavior, much like the imprinting practiced by lower animals, birds, and primates of all kinds upon their birth.[28] Long ago, the psychologist Carl Jung proposed the value of archetypal models as symbols for both aspiration and inspiration among humans of all types. Both history and literature give us examples of sinners and saints, heroes and villains in medicine. Modeling in medical education is a vital but poorly articulated component of professional development.[29] Historically neglected by academic institutions, such instruction seemed relegated instead to the producers of "M*A*S*H*," "Medical Center," "Marcus Welby, M.D.," "Dr. Kildare," and other nostalgic television programs.

Finding a Chad Everett or a Hawkeye Pierce in medicine *today* is perhaps more difficult than finding a hotheaded and arrogant young Dr. Doug Ross (George Clooney in "E.R."). Albert Schweitzer was not a modern physician and neither were Galen, Sts. Cosmas and Damian, Freud, Pasteur, Curie, Salk, or Osler. Academic medicine can advance via our recognizing humanistic excellence and nurturing the concept of model clinicians as one way to keep the requisite clinical virtues foremost in the minds of students and residents. Through the use of models of excellence in the clinical, research, academic, and administrative settings, teachers may be more successful at inculcating archetypal values and virtues in their charges.

Similarly, we may also learn from mistakes, misadventures, and misbehaviors— our own or those of others. Models of medical villainy are legion and may be

used as a benchmark for ethical and professional failure be they historical (e.g., Drs. Josef Mengele, Harold Shipman, and arguably, Jack Kevorkian) or fictional (e.g., Chaucer's physician and Drs. Frankenstein, Jekyll, and Chillingsworth, the last from Hawthorne's *Scarlet Letter*[30]). Although we may not necessarily wish for students to idolize the young Dr. Carter from the television show "E.R.", for example, it is incumbent on faculty to *provide exemplary behaviors* that will model professionalism and lead to academically successful, technically competent, resiliently humanistic, and emotionally mature physician progeny.

> *The vanity of teaching often tempteth a man to forget he is a blockhead.*
> George Savile, Marquis of Halifax, *Maxims*

An essential component of effective teaching of ethics and professionalism in graduate medical education is the competence and preparation of the faculty. As part of faculty development, those who would call themselves "professor" must deal with issues of professionalism among their peerage. Although many of these less technical areas of medicine are common sense and can be learned by experience, a more unified approach to faculty development is warranted to ensure uniformity of behavior and coherence of material within the program. Clear performance expectations should be stated. There are issues that many believe can have several "appropriate" levels of behavior, such as interactions with drug companies, dating between faculty and residents or staff, and financial issues. Residency program faculty must set a group standard for these behaviors and then adhere to them. Faculty members serve as role models for resident professionalism; we cannot expect residents to perform in a more professional manner than their superiors.

To further buttress professionalism, less traditional didactic teaching modalities may prove effective. Some examples of innovative educational techniques may include the use of multimedia presentations, role plays, drama, and other creative educational techniques that emphasize the art, and not merely the science, of medicine. Videos, movies, panel discussions, drama presentations, role-play exercises, and interactive computers have resulted in superior attention, interaction, test scores, and retention of information in teaching clinical skills, procedural skills, and interpersonal skills, distance learning, quality assurance and peer review of patient encounters, and public education.[31–43]

Mentorship: Teaching Professionalism and Beyond

In addition to using modeling and multimedia technology to teach professionalism, the creation of adviser–advisee dyads holds tremendous potential for fostering professionalism and, when necessary, remediation. The term "mentor" has Homeric origins, first appearing in Greek mythology as the name of the trusted friend who watched over Ulysses' son Telemachus, as the King himself went off to fight the Trojan War. The son of Alcimus, Mentor was devoted to the tradition and greatness from whence Ulysses came. Indeed, were it not for him, the glory of the house of Ithaca would have been lost during Ulysses' long absence. So central was Mentor's role, that even the goddess Athena took his form when assisting Telemachus in his quest to find his father.

However mythical its origins, the concept of mentorship has survived the millennia intact. The notion of mentorship has remained particularly compel-

ling in professional circles, as the demand for mentors seems to keep them in short supply. With proper training and legitimation of the mentor's role, new mentors can be groomed from the extant ranks of the faculty.[44] Program directors and assistant program directors may have a particular calling to mentor, but researchers, administrators, and other academics may also have a vocational commitment to lead, nurture, and counsel residents and students. A seasoned mentor's potential role in helping young learners find their way cannot be overestimated.[45] Just as the parentless but popular fictional wizard Harry Potter needed the mentorship of both Rubeus Hagrid and Professor Dumbledore, so too do our academic progeny need guidance and protection.

Mentorship may mean different things to different people, but the central role of guidance and protection remains. For some, this may mean helping charges recognize their strengths and weaknesses, both inside and outside the hospital.[46] It is no secret that many new interns are undecided about their chosen specialty or path upon starting their program, and the good mentor helps them explore their fitness for their future job. This may involve an exploration of the virtues and vices of a candidate on several levels: physical, emotional, intellectual, and spiritual. A student, for example, who is decidedly a morning person with a keen sense of smell and is thereby deeply offended by nightshifts and malodorous feet, respectively, might be better suited to the laboratory or non–patient care activities.

A mentor is a vocational midwife or *trainer* that will help students find themselves in the forest of modern medicine, and through this coaching relationship, trainees may ultimately embrace professionalism through discernment of personal mission or calling. In academic medicine, that may mean a calling to research, education, clinical operations, or administration, but in every case, the mentor will help the peg—square, round, or oval—find its matching hole. The conversation of mentor and student is necessarily broad, but it informs the notion of finding one's place in the cosmos of profession in a life-affirming and powerful way. According to the philosopher Lee Hardy, the spirit of self-discovery enlightens our quest for professionalism:

> if work is a social place where our gifts are to be employed in the service of our neighbor, then two obligations follow: to discover and cultivate our gifts, and to locate the place where those gifts can be exercised for the good of the human community. (p. 124)[47]

When there is correspondence of calling and work, professionalism and purpose flow effortlessly.[48] By enabling residents to freely discern their gifts and design their life work to take advantage of those gifts, mentors help optimize the learners' chance for fulfillment in their profession.[49] This exploration may occur inside or outside the academic setting, but role boundaries must continue to be respected, even when exploring such issues as passions, hobbies, fears, and hopes.

Keeping the lines of communication wide open, including the use of e-mail,[50] pagers, and even cell phones, expresses a genuine and abiding concern to the student or resident and ultimately helps to teach students that they too have duties of professionalism that extend beyond the hospital campus.[51]

Mentorship has a particular role in monitoring behaviors that transcends routine evaluations as currently practiced in most programs. Mentor remediation of unprofessional behavior is done in the spirit of helping, not punishing.

Programs should have a uniform approach to residents who require remediation, including appropriate documentation of skills in professionalism and ethics, as well as other clinical areas. Deficiencies should be appropriately documented and addressed at regular intervals, no less than twice yearly, but more frequent visits with the faculty mentor or advocate may be particularly effective. In some cases, the utilization of outside evaluation and remediation, including psychiatry, social work, clergy, and so forth, may be indicated to help trainees via multiple mentors to expand the role of mentor ombudsman to other parties.

Whereas many faculty view advising and mentoring as an extracurricular, nonteaching burden,[52] most teachers see such an advisory role as an integral part of their vocation.[53,54] With the breadth of interpersonal and professional challenges, and the number of off-service residents who are from foreign countries, faculty mentors must be culturally competent as well as sensitive to the types of human tragedies that residents may suffer during training. Faculty must also avert the pitfalls of making defamatory comments or statements that harm a learner's reputation. Mentors must also be on guard against giving too much advice, in addition to averting biases, harassment, and conflicts of interest. Ethically sound mentors are more likely to produce ethical and morally sound professionals as well.[55]

There is a rich literature to mentoring science, with substantive evidence that developmental approaches that focus on potentialities and active learning are superior to prescriptive mandates with their focus on rules, prodding, and passivity.[56,57] Chickering and Gamson have shown that the most important factor in student motivation and involvement is the frequency of faculty–student interaction, both inside and outside the classroom.[58] Kramer, Tanner, and Peterson have emphasized the mutuality of the mentoring enterprise:

> faculty should develop a caring attitude and personal regard for students. Long after the students have forgotten the information and advice faculty have given them, they will remember the gift of self.[59]

Mentoring engages students and residents in the conversation of what their life will be about[60] and focuses on their interests, skills, and life goals as professionals.[61] This approach has also been shown to enhance the mission of lifelong learning by increasing the human capital and productivity of the participants.[62] Drew Appleby reflects on the value of the educational enterprise when mentors are involved by quoting Henry Cardinal Newman[63]:

> [University training] shows us how to accommodate ourselves to others, how to throw ourselves in their state of mind, how to bring before them our own, how to influence them, how to come to an understanding with them, and how to bear with them."[64]

This consideration for others, I submit, is integral to professionalism and is the prize of a well-mentored medical education. Although being a mentor is not for everyone, many aspire to find a humble, wise Yoda (Luke Skywalker's mentor) who may honor our own dreams and visions, bring out our best, and help us realize that, in spite of current odds, one person can still make a difference.

Conclusion

Professionalism is an old idea but a new core competency for all of medicine. Integrating and inculcating this traditional value and skill into the moral consciousness of contemporary physicians will require nontraditional means. These methods will involve a greater investment of faculty commitment if outcomes-based learning and teaching of professionalism is to be effective. I have argued that professionalism may be fostered in multiple ways, including but not limited to explicit delineation of rules and the judicious use of models and mentors. Perhaps through innovative approaches such as these, the lives of our student and resident charges may be transformed so that, joined with caring faculty exemplars, their performance will illuminate the academic and hospital landscape with a kind of grace and character that grows renewed moral commitment, a newfound patient-centeredness, and a transcendent professionalism in the art and science of modern medicine.

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