Teaching professional development in medical schools

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Doctors must increasingly be aware of what they should be, as well as what they should know. Professionalism, including a value system that supports the compassionate care of patients, is a means of encapsulating and prioritising these competing responsibilities. Accordingly, in this article, we assume that professionalism is an essential aspect of medical practice that needs to be taught to those entering medicine. We first describe critiques of professionalism and current challenges to it, in practice and in medical education. We then assess the current efforts of curriculum reform to incorporate professionalism and the methods used to teach it. Adopting and assessing such approaches to ensure that they are effective is of central importance in the education of future clinicians.

Nearly a century on from the Flexner report, key questions about the medical profession have once again thrust themselves centre stage. In an era of calls for evidence, team care, accountability, empathy, and understanding, while simultaneously being concerned about personal and career fulfilment, doctors risk being pulled in different directions. As a result, specific professional norms and expertise could be called into question.

The classic triad of professionalism consists of a high level of intellectual and technical expertise, autonomy in the practice and regulation of the discipline, and a commitment to public service. The intellectual skills and education of doctors have seldom been doubted, and medicine has usually managed to evade close external regulation. This independence has excited criticism from some outside observers. George Bernard Shaw famously pilloried the seemingly conspiratorial conformity of the profession, suggesting that the medical profession made decisions only guided by “the sort of conscience that makes it possible to keep order in a pirate ship or a troop of brigands”. The authority of professionals could also be construed as wielding power, ultimately the power to create and preserve a monopoly of practice. In the eyes of some, such a monoclature has allowed medical practitioners to work impervious to criticism, unaware or unaffected by the impact of their decisions on other aspects of their patients’ lives or on public welfare.

The success of medical science has, ironically, posed challenges to the independence of professional medical practice. For instance, as the costs of health care rise and efforts are made to control them, variations in the quality of care have become more obvious. Some variations are clearly unacceptable and have led to attempts to standardise medical skills and to implement mechanisms of supervision. Yet such contemporary challenges are simply the modern versions of older conflicts. If doctors in the past have been uninfluenced by funding constraints, it is because they chose to ignore this difficulty in a way that their patients (paying or otherwise) could not. Although the profession has largely ignored commentators who suggest that medical practice is not only risky but also actually creates illness, the possibility of medical harms or malpractice had always been part of popular folklore. When it comes to rotten doctors, the subsequent careers of whistleblowers seem to confirm Shaw’s view of medical conformity. Further, the battle between homoeopathy and allopathic medicine, representing a struggle to define the boundaries of medical practice, reaches back 200 years. Medical students should, therefore, be forewarned about the tensions associated with joining a profession that has always faced threats to its independence—but threats that can usually be countered by a clear commitment to advancing the interests of patients. Such a commitment could be embodied in the compassionate care of both individual patients and populations, thereby completing the triad of professionalism.

Experience of medical education

Becoming a doctor is a right of passage, in which those in the transitional stage are most vulnerable. Attitudes and activities established here can persist long term, so it is essential to ask, what do we know of this process? Gaining a medical degree can be rewarding in all sorts of ways but might also be achieved at a cost that is more than financial. To be able to look objectively at, and think dispassionately about, an ill or dying patient, the new doctor might create distance from the emotions that such situations evoke. Smith and Klenan suggest that student strategies could include “transforming the patient or the procedure into an analytic object or event [...]”, blaming patients [...], joking and avoiding sensitive contact”, and more laudable tactics. Whereas for some this technique might be a means adopted simply to get by, for others it will create more serious internal emotional separation that could have repercussions later in their personal lives.

All medical students, to a greater or lesser degree, are overwhelmed by the quantity and complexity of the facts and technical interventions, anxious about death and disease, driven by assessment, and encouraged to be competitive. Some might also be bullied and humiliated by superiors, be given excessive responsibility, and be overworked and deprived of sleep. Furthermore, most students usually receive very little support or time to think and rest. An anthropologist going through medical training in the 1980s wrote: “I view the clinical training
reduce the fragmentation of knowledge and acquisition of meaningless facts, to promote curiosity and teamwork, and to present a patient rather than a disease model. The introduction of role-play and simulated patients has further provided what seem to be appropriate environments in which to develop professional skills.

**Student and teacher support and guidance**

Curricular initiatives generally assume that the professional development of any student is predicated upon the support and guidance that they receive from teachers. Because the recognition of areas of strength and weakness, and the redressing of weak areas would seem to require a trusting relationship with teachers, one-to-one or small-group relationships with supervisors, advisors, and mentors have been used to help carry out such tasks. To foster self-awareness and wellbeing, group activities such as literature discussion groups and Balint groups have been encouraged. The latter work toward a better understanding of the emotional content of the doctor-patient relationship. Furthermore, pastoral care should help students with the stresses that they experience during medical training.

**Assessment and appraisal**

Assessing students’ professional development adds to the value placed on professionalism by students and teachers. In-course assessment, by providing a variety of measures over time, perhaps gives a fairer view of students’ professional conduct than end-of-course assessment alone. Formative assessment provides the student with information about how the level and quality of their knowledge, and their skills and attitudes, are judged by their tutors, patients, and peers. This information allows the student to participate in assessment and highlights clear areas for improvement.

More recent assessment methods, which could be of particular use in the measurement of professional development, include the writing of short narratives (about important incidents that illustrate situations which students found especially educational) and the Objective Structured Clinical Examination. Peer-assessment and self-assessment, and appraisal have been suggested as further tools to be used in the undergraduate curriculum, and have relevance to professional development. With appraisal, feedback can be used as a platform from where personal goals and development can be charted and followed.

**Moving forward**

Although such reforms promise to be fruitful, several other areas deserve special attention. These include student selection, recognising the hidden curriculum and using it to supplement formal curricular efforts, providing teachers who are good role models, recognising diversity and cultural aspects of medical practice, and learning about teamwork in both primary and secondary care settings (panel 2).

Can student selection influence outcomes? Some research has suggested that professional attitudes change modestly, if at all, during medical training. Other studies, such as that by Eron, indicate that students’ cynicism increases and humanitarianism decreases. However, some evidence suggests that such changes are transient, being a response to the training environment. Despite these counter-arguments, selection of students who show caring qualities and then seeking to keep these intact through medical training could contribute to the production of good doctors.

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**Panel 1: Key aims of professional development during medical school**

- To enable students to understand the origins of professionalism and the proper set of responsibilities of the professional.
- To instil and nurture in students the development of personal qualities, values, attitudes, and behaviours that are fundamental to the practice of medicine and health care.
- To ensure that students understand the importance and relevance of these concepts, demonstrate these qualities at a basic level in their work, and are willing to continue to develop their professional identity.
In the hidden curriculum of medical education are the processes, pressures, and constraints, which fall outside of, or are embedded within, the formal curriculum, and that are often unarticulated or unexplored. These include the educational, structural, social, and cultural aspects that lie beyond formal teaching. Whereas pedagogical discussions tend to focus on the content and processes of the formal curriculum, the hidden curriculum has a great effect on the professional development of students and deserves serious inquiry.

Good role modelling could be of primary importance in the medical school environment. Students face difficulties in trying to retain their compassion when, on the one hand, they are told to value the concept of caring but on the other the see practices based on competition, economic concerns, and the misuse of authority. Consequently, a suggestion has been made that educators themselves should attempt to embody the values and behaviours that are desired of students and new doctors.

During their training, students learn from each other and from the many people and communities with whom they work. That undergraduate medical students remember their own origins and perspectives, and the biases that they hold, is, therefore, important, since such knowledge allows them to cultivate responsiveness to the needs and values of those they serve. Furthermore, in learning from those with whom they will work, and in learning to work as part of a team, students should discover the importance of teamwork when providing care. In the USA and UK, the increase in specialisation, shortened hospital stays, and an emphasis on community health care has led to a rising proportion of undergraduate medical education taking place in community settings. This trend has important benefits for training in that a community education can provide a student with many of the models with which to promote professional development. These include learning about diverse communities, long-term care, whole-person medicine, teamwork, and population medicine, often in one-to-one or small group situations.

To develop and deliver curricula that have strong professional components, tutors and teachers need training and support. In clinical practice, a proper consultation should be responsive both to the medically objective requirements of the patient and to the values and emotional needs of those involved. However, although delivery of such care might be within most physicians’ capabilities, teaching the skill is quite another matter. The reality is that to teach safe and sensitive medicine at the same time as consulting could put strain on the skill and character of the physician, on the doctor-patient relationship, and on the structure and organisation of health care. Nevertheless, the efforts at curricular reform described above have been instituted to enable the teaching of professionalism. The medical school should be in a position to receive feedback from the community that it serves and to modify its teaching accordingly. Finally, to be effective, the whole process will need firm commitment from medical school leadership, including placing professional development at the centre of medical training, the place it surely needs to be to promote the compassionate and appropriate care of patients.

Conclusions

A commitment to formal curriculum reforms and broader reaching approaches to the teaching of professionalism is an important first step in preparing medical students for the challenges that lie ahead. Only rigorous research will tell whether such efforts are effective. Medical education is not short of excellent ideas about how to improve courses and create the professionals needed by society. What is in much shorter supply is evidence about the effectiveness of such teaching, even reports of methods used with simple internal assessment. Medical education has only recently become a subject for essential study, and its methods are still contested. Maybe we are not yet thinking broadly enough about the methods needed to assess it? Cribb recommends a liberalisation of current approaches, which entails a greater scepticism and a broader mind in moving beyond the purely positivistic to encompass the examination of culture and context. Nevertheless, professional development is a process at the heart of medical training. The learning environment, both hidden and formal, must support rather than undermine the development of professional qualities. Professional development needs fostering as an integral part of all medical training, embedded in experience and associated practices. Assessment of professionalism helps to ensure that students display the basic values, attitudes, and behaviours expected of doctors.

We do not envisage that the cultivation of professionalism will require a substantial increase in resources. Rather, professional development could require a change in focus that would in turn lead to different priorities for existing resources. The teaching and assessment of key areas inherent to professionalism such as medical ethics and population-based medicine must be given proper emphasis alongside scientific training. An improved teacher-training programme and student-support system is essential and could necessitate some extra input. However, improved role modelling and an emphasis on professional development within existing teaching programmes will probably remain the cornerstone of enhanced practice. Medical schools must incorporate professional development into the curriculum to ensure that the next generation of physicians is positioned to practise humanistically in a world of increasing and competing demands.

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References
