Viewpoint: **Are We Serious About Teaching Professionalism in Medicine?**

John W. Saultz, MD

Abstract

Medical professionalism is an increasingly common topic of discussion in the medical education literature. Much of the recent literature on this subject addresses areas of weakness in the educational curricula of medical schools and residency programs. But students are living a world in which professional behavior is being redefined, often in ways that run contrary to the medical education curriculum. This article outlines three fundamental challenges that powerfully affect the ability to promote professionalism in students and young physicians. To overcome these challenges, the author suggests four steps that can be taken in the medical education community. First, medical schools should address cost and access to care as first-order intellectual problems and should encourage research programs in these areas. Second, schools should develop programs to humanize science and restore scientific integrity beyond the requirements of compliance programs. Next, medical school leaders should celebrate those who best embody moral leadership in the profession. Finally, the medical education community should acknowledge that the availability of affordable health care to the public depends on the practice choices of medical school graduates and should accept greater responsibility for this outcome.

Acad Med. 2007; 82:574–577.

Over the past several years, there have been articles in *Academic Medicine* and other scholarly journals calling for U.S. medical schools to enhance curricular emphasis on professionalism.[1–3] The Accreditation Council for Graduate Medical Education has included professionalism as a core competency to be taught to all residents regardless of specialty, and programs around the country have struggled with how best to teach values in a system designed primarily to teach knowledge and skills.

A profession may be defined as any group sharing a special body of knowledge, standards of education and practice, and an ethical framework based on a social contract that permits self-regulation.[4] The nature of this ethical framework is often characterized by a foundation of altruism and public service.[5] Those who value medicine's status as a profession would like the public to believe that caring for patients and the communities in which they live is a moral calling and not simply a vocational choice for physicians.[4,6,7] However, many believe that the past 20 years have witnessed a progressive deterioration of medicine's commitment to the public good.[4,6] Has professionalism really deteriorated? If so, why has this occurred, and is it really that important that the trend be reversed? Is this simply a curricular problem rooted in how young physicians are taught, or is the problem more fundamental?

On the basis of my experience on the front lines of American medical education, I believe that declining professional standards are a serious threat to our profession and that those authors calling for change have, if anything, underestimated the challenges we now face. Simply creating a new curriculum for students and residents may fail to reverse this trend. Indeed, the problem lies not in what we fail to teach our students, but in what we teach them every day by our own actions and inactions in medical schools' "hidden curricula."[8,9] I spend each day seeing patients and teaching young people as they work to learn our profession. I learn a lot from listening to these students as they struggle with their own career choices amid the anxieties we all have about American medicine's future. What I have learned from students should be cause for great concern for anyone who respects medicine's position of moral authority in our society. Of course, one could argue that these are really not new problems—that there has always been a gap between our rhetoric and our reality. More than 20 years ago, Paul Starr's book, *The Social Transformation of American Medicine*,[10] outlined many of these same points in describing how our profession had changed. But I believe things have become far worse over the past decade and have now reached a crisis point, or "tipping point," to borrow a phrase from Malcolm Gladwell.[11]

Challenges to Professionalism

American medicine's moral crisis can best be understood by examining three underlying trends that collectively shape the public's growing distrust of our profession. First, and most important, is the increasing number of Americans who lack access to affordable health care and the impact this loss of access has on their lives, liberty, and happiness.[12,13] Second is an apparent loss of trust in our scientific community as research scandals rock our academic institutions and the integration of new knowledge into clinical practice is compromised by doubts regarding conflicts of interest.[14–20] Finally, the slow replacement of our professional standards of conduct by business standards calls into question the balance of attention being paid to community interests versus self-interest.[9] Taken separately, each of these problems represents a daunting challenge for the future of medical education and practice; considered together, they attack our

Dr. Saultz is professor and chairman, Department of Family Medicine, Oregon Health & Science University School of Medicine, Portland, Oregon.

Correspondence should be addressed to Dr. Saultz, Department of Family Medicine, Oregon Health & Science University, 3181 SW Sam Jackson Park Rd., Portland, OR 97239; telephone: (503) 494-6602; fax: (503) 494-4496; e-mail: (saultz@ohsu.edu).

professional credibility along three broad fronts that defy simple solutions.

There is now remarkable consensus about the single most important problem facing American health care. Escalating health care costs are now putting affordable care out of reach for too many of our people. Although this has always been a problem in the United States, until recently it has affected primarily the poor, and we have been able to construct safety net systems to fill the gap between private practice and public need. Today, loss of access has become a major worry for many in the middle class; even those with health insurance worry about losing it. As this trend worsens, American academic medicine has precipitously reduced our production of those physicians most likely to address the problem. Broadly trained generalists and primary care physicians have always formed the foundation of American medicine, but they have also made up nearly all of the safety net, whether we examine federally qualified community health centers, public health clinics, or rural practices.[21] Many of our academic leaders seem content to ignore this problem, stating that market forces should determine the medical workforce. But market forces will never drive supply toward a demand base that cannot pay for the product without a revenue source that will at least cover the cost of care.[12] Thus, the problem worsens as each day goes by and little concerted action occurs on our part. It simply cannot be overstated how dramatically our inattention to this affects those applying to and studying in medical school. Are we, their teachers, providing moral leadership, or are we content to let things evolve while remaining silent? What conclusions do students draw from our silence?

Concerns about research integrity have now become so commonplace that extensive government bureaucracies have been established to protect the public interest. Funding from industrial interests is so ubiquitous that only a small minority of medical school faculty are not receiving such support. This has been the subject of numerous editorials and essays and is a topic of frequent discussions on our medical school campuses.[14,17–19] An alarming portion of our clinical research is now funded by organizations that will directly benefit financially from how clinical practice does or does not change. My experience with physicians in Oregon suggests that many practicing physicians no longer trust medical journals or academic authorities to provide unbiased, clinically relevant information. Each new scandal further undermines this trust. Any doubt about this can easily be erased by simply attending a residency journal club meeting; the source of research funding is often among the first items identified as a bias to any study being reviewed. What is the point of advocating evidence-based medicine if the only evidence we generate is tainted by perceived self-interest? This problem is quite apparent to our students and residents. They notice that we discuss research integrity as an issue of compliance rather than intellectual honesty. Our language betrays our willingness to allow regulators to define our standards of integrity, as we no longer do so ourselves.

How many of our not-for-profit hospitals and academic health centers (AHCs) have implemented programs to manage the payer mix of our practices as the gap between reimbursement from public and private sources of insurance widens? Physicians state, with an alarming absence of conscience, that they can no longer afford to care for hospital patients or visit patients in nursing homes. Rising costs of practice operation have resulted in physicians seeing ever-increasing numbers of patients each day.[22] Our response to these cost increases is to bring more and more business acumen to bear on how our practices operate. Consultants visiting our institutions talk incessantly about efficiency and productivity, but there is a deafening silence about the moral dimensions of these business decisions.

In my own community, some physicians now refuse to be on call or to care for patients being admitted from the emergency department unless they are paid by the hospital. Perhaps we are only willing to live up to our professional obligations if someone pays us to do so. Is this occurring because physician incomes are declining? Has it become impossible to support our families without taking these steps? In the past, physicians have generally not been paid well for caring for undoctored patients in the hospital. They have done so as part of their professional obligation to the communities in which they practice. But the number of such patients has increased significantly, and our own comfort with business excuses for our professional lapses has grown as well. Are these trends occurring because a new generation of physicians has failed to learn from their teachers? No, I think instead that the new generation is learning this behavior from listening to us make excuses for behavior we once would have condemned.

Ideas for Addressing These Challenges

So, what can be done to reverse these trends? Can a new curriculum herald a resurgence in professional behavior? Can this happen before the public finally concludes that physicians are the problem and not the solution for our ailing health system? Actions speak far louder than words. A new professionalism curriculum is surely destined to fail if it is not accompanied by serious changes in how we approach our daily work in academic medicine. Although no doubt necessary, a new curriculum alone will be insufficient to change the hearts and minds of our students. Consider the following initiatives as ideas that could contribute to such a change.

Address cost and access to care as first-order intellectual problems

At present, many medical school faculty members act as though access to care is a policy problem and is thus not worthy of scholarly attention. But many of the most important health care problems facing the American people today are policy and economic issues. Studying such policy problems must become part of our intellectual mission. Poor funding for policy research has surely contributed to our lack of attention to this type of inquiry, but the rate-limiting step in translating research into improved health outcomes is now the inability of a growing portion of our population to afford these new treatments. What would happen if every American medical school committed some of our best minds to working on the problems of cost management, improved care delivery, and the dissemination of new knowledge? Imagine if we did so in a collaborative and very public partnership with our communities. In part, this is what is

envisioned by the new National Institutes of Health initiative in translational research.[23] But many medical schools still systematically underemphasize the essential elements of population science and policy research. If we want to continue to be taken seriously in our communities, the public needs to know that we care about problems that matter most to them. Also consider how such an effort would affect our medical students, residents, and young faculty members. It is simply not sufficient for us to talk about social justice without putting more of our intellectual energy into achieving it.

Humanize science and restore scientific integrity beyond the requirements of compliance programs

Public debate about medical research now centers on stem cell biology and disease-oriented biomedical research. These exciting and important areas of new science must remain central to our cutting-edge research agendas. But such work is at serious risk of outpacing its own relevance. Developing a new treatment can only be important to the public if they understand it and if they believe that it might directly benefit their own families. At present, they don't understand our work as well as they might, and they definitely are no longer confident that new treatments will be within their economic reach. Imagine the impact of a research strategy that both creates new technology and assures that these advances are understood by the taxpayers and consumers who ultimately must support our work. Consider the effect on our funding if the public trusted that our standards of integrity exceeded those of the government and institutional bureaucrats assigned to watch over us. How will the next generation of students and residents be affected by such transparent accountability on the part of their teachers and mentors? These things will not happen if we don't toughen our own standards. Reporting conflicts of interest doesn't seem to be sufficient. We must limit such conflicts by setting and enforcing standards that, although unpopular, will restore integrity at this critical time. Such standards must come from within the research community if they are to be credible. Professionalism is not about following government rules; it is about self-regulated standards of integrity.

Celebrate those who best embody moral leadership in our profession

Our current system of promotion and recognition in academic medicine can be quite corrosive to those trying to simply do the right thing. Financial incentives and academic recognition usually flow to those who play the academic game well. Rarely does this game entail real moral leadership. Instead, we value leaders who can create productive compromises between self-interest and public interest, between our science and our students, between our practices and our patients. But perhaps we have compromised too much and too often at the expense of those we are obliged to protect. In each of our institutions are those faculty members whose rectitude of personal and professional conduct engenders both envy and resentment. We are sometimes frustrated with their unwillingness to get along. But consider how much worse off we would be without them. Our students and residents must be taught that there are standards that we will not compromise. Those who compromise all the time are hardly the ones to teach them about this. In his important book, *Lives of Moral Leadership*, Robert Coles[24] states:

> We need heroes, people who can inspire us, help shape us morally, spur us on to purposeful action—and from time to time we are called on to be those heroes, leaders for others, either in a small, day-to-day way, or on the world's largest stage. At this time in America, and in the rest of the world, we seem to need moral leadership especially, but the need for moral inspiration is ever present.

What would it be like if every medical school had a process to recognize and celebrate those who live out our professional ideals every day? What if our students could see medical professionalism at its best, recognized as such? Service has always been central to the mission of an AHC, but this mission requires constant reinforcement.[25]

Acknowledge and take responsibility for the relationship between the practice choices of our graduates and the availability of affordable health care to our people

Those of us in academic medicine understand that our institutions are complex networks of scientific, clinical, and educational endeavors. We understand that AHCs are as diverse as those who work in them. But to the public, the primary mission of a medical school is to train physicians to care for people. Thus it is that we are often *judged* by our educational product, even if we are *paid* primarily for our scientific and clinical work. Perhaps this is why the public often seems to care more than we do about what our graduates do after graduation. As medical education becomes more expensive, those applying to medical school are more often from economically privileged backgrounds. They are looking less like the public as a whole, and recent data suggest that they are less frequently entering practice in the areas of greatest need. This is true in terms of specialty choice and even truer in terms of ultimate practice location. Recent declines in primary care career choice have resulted in less public and academic debate than similar trends that occurred in the 1960s and 1980s. Do we really think that technology will eliminate the primary care function? Can we actually believe that declining student matriculation into primary care will have no impact on the public health? If fact, the evidence is quite overwhelming that health systems without an adequate primary care base are both more expensive and have poorer health outcomes.[26]

So, what is our plan? Will we wait for the problem to worsen or for government pressure to be brought to bear, as it has in the past? Pretending that this isn't a problem has a remarkable effect on medical students. They are asking the most insightful questions about what career choices will best give meaning to their lives. My experience suggests that it really isn't income or prestige most of them seek—it is fulfillment. However, it is also true that they experience almost daily discouragement when they consider careers of community service. It is one thing to learn medicine from people who don't seem to understand the importance of moral service to our professional tradition. It adds insult to injury to hear disparaging remarks from those same teachers about those who have chosen this path. An ethic of service to the community is an essential element of medical professionalism.[4,6,7] Those who chose this path aren't naïve or stupid; instead, they represent the best of our profession. How often do we tell them so?

The Change Must Begin with Us

So, what conclusion might we draw from these ideas? I do not think we have long to begin taking the issues of integrity and professionalism in medicine far more seriously than we have to date; our public trust and professional reputations are truly on the line. More important, our self-respect may also be at stake. Few of us chose a career in medicine planning to stand by while our profession ignores the most important problems facing our communities. Wasn't it the moral calling of this profession that was in our hearts when we applied to medical school? So, what has happened to us? It seems clear to me that neither the government nor our institutional leaders are likely to create the kind of change that is required. Such a change in attitude and behavior must take place in each of us. The larger system will only get better when we insist that it does.

References

1 Whitcomb ME. Medical professionalism: can it be taught? Acad Med. 2005;80:883–884.

2 Huddle TS. Teaching professionalism: is medical morality a competency? Acad Med. 2005;80:895–891.

3 Kao A, Lim M, Spevick J, Barzansky B. Teaching and evaluating students' professionalism in U.S. medical schools, 2002–2003. JAMA. 2003;290:1151–1152.

4 Pellegrino ED. Medical professionalism: can it, should it survive? J Am Board Fam Pract. 2000;13:179–179.

5 Hafferty FW. Definitions of professionalism. Clin Orthop Relat Res. 2006;449:193–204.

6 More ES. The remains of the profession, or what the butler knew. Ann Intern Med. 2001; 134:255–259.

7 Bryan CS. Medical professionalism and Maslow's needs hierarchy. Pharos Alpha Omega Alpha Honor Med Soc. 2005;68:4–10.

8 Suchman AL, Williamson PR, Litzelman DK, Frankel RM, Mossbarger DL, Inui TS. Toward an informal curriculum that teaches professionalism: transforming the environment of a medical school. J Gen Intern Med. 2004;19:501–504.

9 Rothman DJ. Medical professionalism—focusing on the real issues. N Engl J Med. 2000;342:1284–1286.

10 Starr P. The Social Transformation of American Medicine. New York, NY: Basic Books; 1982.

11 Gladwell M. The Tipping Point. New York, NY: Little, Brown and Co.; 2000.

12 Reinhardt UE. Wanted: a clearly articulated social ethic for American health care. JAMA. 1997;278:1446–1447.

13 Woollard RF. Caring for a common future: medical schools' social accountability. Med Educ. 2006;40:301–313.

14 Blumenthal D. Academic–industrial relationships in the life sciences. N Engl J Med. 2003;349:2452–2458.

15 Bekelman JE, Li Y, Gross CP. Scope and impact of financial conflicts of interest in biomedical research—a systematic review. JAMA. 2003;289:454–465.

16 Krzyzanowska MK, Pintilie M, Tannock IF. Factors associated with failure to publish large randomized trials presented at an oncology meeting. JAMA. 2003;290:495–501.

17 Johns MM, Barnes M, Florencio PS. Restoring balance to industry–academia relationships in an era of institutional financial conflicts of interest. JAMA. 2003; 289:741–746.

18 Angell M. Is academic medicine for sale? N Engl J Med. 2000;342:1516–1518.

19 Brennan TA, Rothman DJ, Blank L, et al. Health industry practices that create conflicts of interest. JAMA. 2006;295:429–433.

20 Als-Nielsen B, Chen W, Gluud C, Kjaergard LL. Association of funding and conclusions in randomized drug trials. JAMA. 2003;290: 921–928.

21 Rosenblatt RA, Andrilla CHA, Curtin T, Hart LG. Shortages of medical personnel at community health centers: implications for planned expansion. JAMA. 2006;295:1042–1049.

22 Bodenheimer T. High and rising health care costs. Part 3: the role of health care providers. Ann Intern Med. 2005;142:996–1002.

23 National Center for Research Resources. Clinical and translational science awards. Available at: (http://www.ncrr.nih.gov/clinicaldiscipline/CTSA_FactSheet.pdf). Accessed March 20, 2007.

24 Coles R. Lives of Moral Leadership. New York, NY: Random House; 2000.

25 Coleman DL. The impact of the lack of health insurance: how should academic health centers and medical schools respond? Acad Med. 2006;81:728–731.

26 Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83:457–502.

Did You Know?

This year, Oregon Health and Science University established the nation's first federally funded center for studying methamphetamine abuse from its genetic underpinnings to its prevention through public education programs. With a grant from the National Institutes of Health, Methamphetamine Abuse Research Center will be operated in partnership with the Portland Veterans Affairs Medical Center.

For other important milestones in medical knowledge and practice credited to academic medical centers, visit the "Discoveries and Innovations in Patient Care and Research Database" at (www.aamc.org/innovations).