

Defining medical professionalism: a qualitative study

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BACKGROUND Elements of professionalism are well-described in the literature and medical schools continue to struggle with how to teach these concepts effectively.

PURPOSE The purpose of this study was to investigate the meaning of medical professionalism to medical students, residents, academic faculty and patients and to determine areas of congruence and difference.

METHODS In this qualitative study we conducted 8 focus groups to discover subjects' beliefs, perceptions and expectations of medical professionals. Sessions were audiotaped and transcribed, and themes identified through an immersion/crystallisation process. Concept maps were prepared to aid understanding.

RESULTS Recurring primary themes of knowledge/technical skills, patient relationship and character virtues were identified. Secondary themes were medicine as a unique profession, personal congruence and the importance of peer relationships. There was a shift in emphasis reflecting differing stages in the learner continuum. Although patients desired skilled technicians, their themes focused on relationships. Several unique themes were also identified.

CONCLUSIONS Some elements of professionalism are embraced by learners at all stages and by patients. Notably, when compared to components of the American Board of Internal Medicine Physician Charter, themes relating to social justice elements were lacking. Differences in emphasis by learner groups reflect the inherent challenges to teaching professionalism successfully. Future studies investigating these differing perceptions are needed to help clarify our teaching mission.

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INTRODUCTION

Medical education is not only about the acquisition of new knowledge and skills; it is also about the acquisition of a new identity in life – an identity as a doctor, a medical professional, with all the rights and responsibilities that that entails. Even with the recent emphasis on professionalism, influencing the development of character traits and behaviours associated with professionalism remains one of the most difficult core content areas in medical education. There are numerous descriptions of the elements of professionalism, yet attempts to define the concept have not yet led to widespread success in identifying the faculty and curriculum to teach such ideas efficiently and effectively, nor to definitive tools and methods to evaluate learner outcomes.^{1–3} Many trainees and practitioners report dissatisfaction with their training to handle the challenges to professionalism that inevitably occur.⁴ While there appears to be consensus that medical professionalism should be taught, some educators question whether professionalism can be taught.^{5–7}

Report I of The Medical School Objectives Project established guidelines for medical schools to use in establishing their own learning objectives.⁸ These guidelines incorporated many of the elements of professionalism delineated elsewhere. Swick proposed a normative definition of medical professionalism as a starting point for encouraging dialogue and noted the importance of understanding what it entails.⁹ His definition is behavioural, accounting for the nature of doctors' work, and applies to doctors individually and collectively. Later, Epstein and

Overview

What is already known on this subject

The mandated teaching of professionalism has led to educator concern over how to teach this topic. Definitions of professionalism do not take into account the differing perspectives of learners and patients.

What this study adds

This study adds a comparison of the meanings and perceptions of professionalism by students, residents, faculty and patients, discovered from qualitative analysis of focus groups. It also uses concept maps to illustrate the change in meanings and perceptions through a developmental perspective.

Suggestions for further research

Future qualitative studies with more subjects would add insight that would be helpful in designing curriculum and other approaches to teaching this difficult topic.

Hundert described several dimensions of professional competence that included cognitive, technical, integrative, context, relationship, affective/moral and habits of mind dimensions.¹⁰

The importance of professionalism to the future of medicine was underscored by the 2002 publication of the 'Medical professionalism in the new millennium: a physician charter'.¹¹ The Charter's 'set of professional responsibilities' includes commitments to professional competence, honesty with patients, patient confidentiality, maintaining appropriate relations with patients, improving quality of care, improving access to care, just distribution of finite resources, scientific knowledge, maintaining trust by managing conflicts of interest and professional responsibilities. The Charter was disseminated widely and has generated much response, but it is not without criticism.¹² Reiser and Banner noted the absence of input from patients in developing the Charter and its lack of emphasis on the doctor's role of healer.¹³ Their criticism is supported by recent work on patient complaints, indicating that patients have definite

opinions about what they expect from care.¹⁴ Frequently mentioned complaints included disrespect, distrust and miscommunication, all of which are opposites of important elements of professionalism.¹⁴ Using survey data, Mann *et al.* recently reported differing perceptions of students, faculty, residents and other health professionals about the extent to which their education met 'non-cognitive goals' and called for research exploring the basis for differing perceptions.¹⁵

In this qualitative study we investigated differences in perception of the concept of medical professionalism among faculty, residents, medical students and patients, using focus groups. The purposes were two-fold. First, we examined the development of concepts of professionalism across the learner lifespan of student, resident and faculty. Secondly, we wanted to compare patient perspectives to perspectives of those in the medical field to determine the elements of professionalism that are critical to the consumer of healthcare versus the practitioner. We anticipated that a developmental approach to understanding professionalism over the progression from medical student to academic faculty member and the insight gained from patients would enhance our understanding of how to teach and promote professional behaviours and attitudes. The study was conducted at the Medical College of Georgia, Augusta, Georgia, with collaboration between the Departments of Family Medicine and Pediatrics. The project was approved by the institution's Human Assurance Committee.

METHODS

We invited faculty and residents from the departments of family medicine and paediatrics to participate in focus group discussions. Students rotating through their junior core clerkship in family medicine were also recruited and paid \$20 for their participation. Active patients in an academic Family Medicine Centre were recruited through doctor referral and were contacted subsequently by a non-doctor investigator. Patients were not selected to be representative of the population. Focus group discussions reached saturation, with no new information being obtained, so opinions can be assumed to be complete. Patients were given an overview of focus group procedures and purposes and invited to participate, with payment for their participation of \$20, the standard amount our department has previously paid for focus group participation. There were 8 focus group sessions conducted between

October 2002 and August 2003 comprised of 51 subjects. There were 2 groups of faculty (1 family medicine, 1 paediatrics, $n = 11$) and 2 groups of residents (1 family medicine, 1 paediatrics, $n = 13$). Sixteen medical students participated in 2 student groups and 11 family medicine patients participated in 2 patient groups. Focus group methodology is ideal for this type of study, where an exploration of beliefs and perceptions is the goal. In groups with small numbers of participants, we encouraged further discussion using a standard script of questions in an open-ended interview manner. Discussions took place in a non-threatening environment and participants were able to relate experiential data that might otherwise have remained unknown. Focus groups were led by 2 investigators each, selected as available from 2 behaviourally trained researchers, a family doctor and a paediatrician. All investigators were women.

At the beginning of each focus group, informed consent was obtained from participants. All participants completed a demographic questionnaire providing date of focus group, subject group identification (faculty, resident, student or patient), age and ethnicity. Focus group facilitators used a set of trigger questions generated from Epstein and Hundert's description of dimensions of professional competence (cognitive, technical, integrative, context, relationship, affective/moral and habits of mind).¹⁰ Trigger questions also included questions about professionalism as a learned or innate behaviour and about potential keys to the ability to learn aspects of professionalism [e.g. Do these characteristics or qualities 'come naturally'? How do doctors (or residents, or students) learn to be professionals? For faculty: How important are other doctors to your own professionalism?]. Each group facilitator initiated the discussion of medical professionalism, with trigger questions and used probes to ensure consistency and coverage of germane topics across groups. An additional investigator or research assistant took notes throughout each session as a back-up to the audiotapes. An investigator then transcribed the audiotapes.

Data analysis was accomplished under the direction of an investigator experienced in qualitative analysis and data coding using immersion/crystallisation.¹⁶ Five investigators reviewed all transcripts independently and identified important items in each transcript. Investigators then reviewed the items and categorised them into themes. Two investigators then reviewed these themes and compiled them into a table listing all identified themes by subject group-

ing. Through an iterative process, duplicative themes within study participant categories were eliminated and major themes and underlying components were identified and refined. The theme table facilitated comparison of faculty, resident, student and patient comments on themes. After perusal and discussion of the resulting theme comparisons by the lead investigator and 2 other investigators, the lead investigator integrated these themes into visual concept map representations. The concept maps help to exemplify relative theme strength and shifting emphases from the 4 groups of study participants. Consensus on themes and the concept maps was reached via discussions among investigators.

RESULTS

Three primary and 3 secondary themes were common to all groups. Primary themes included knowledge/technical skills, patient relationship and character virtues. Secondary themes included medicine as a unique profession, congruency between personal characteristics and outward appearance and behaviour and the importance of peer relationships. Multiple minor themes also were present across all groups. Although these themes were present in all groups, there were differences in emphasis. Figure 1 presents an overarching conceptual map of professionalism when groups are combined. Figures 2–5 present maps of faculty, residents, medical students and patients, respectively. Strength of themes is shown by relative size and connectivity is shown by position in the map and straight-line connectors. First we will present exemplary quotations describing each theme and secondly we will discuss between group differences in emphasis.

Primary themes

The knowledge and technical skill theme highlights the notion that doctors should 'know their stuff'. Words such as 'up-to-date' and 'competent' came from faculty. Residents mentioned 'have to be aware of your limitations' and 'know when to ask for help'. Students spoke of 'lifelong learning' and 'developing a knowledge base'. Patients emphasised competence, efficiency and being capable. In general, everyone believes that knowledge and skill are necessary to maintain professionalism.

The patient relationship theme included an emphasis on trust and confidence. Faculty mention 'patients can believe, trust, and have total confidence in you'. It is a 'balance between being authoritarian and

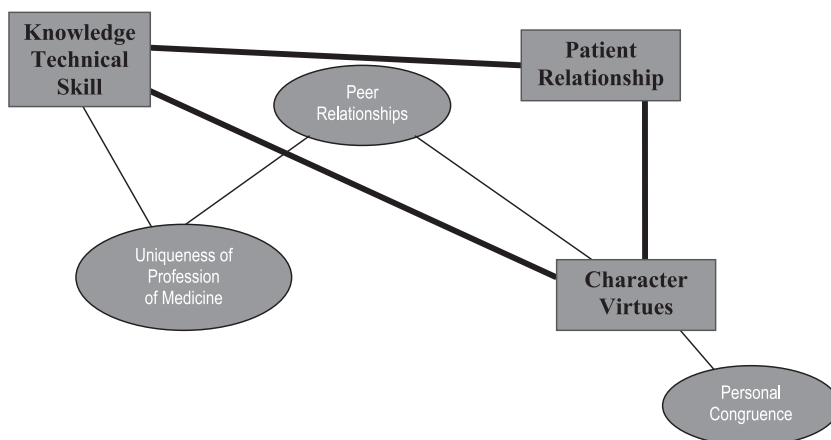


Figure 1 Basic professionalism map

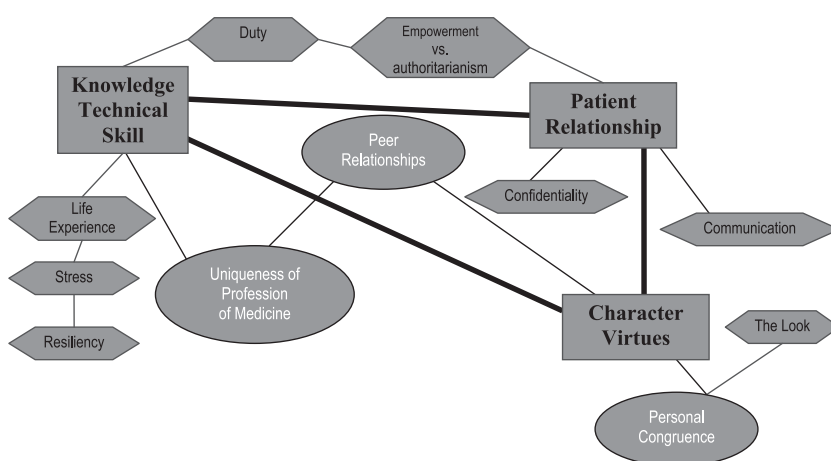


Figure 2 Faculty professionalism map

partnering with patients'. Residents emphasise 'ideally, it's everybody in harmony and give and take' and 'treating people the way you want to be treated'. Students seem to emphasise communication skills, mentioning 'good communication is productive – makes patient comfortable and it's important with colleagues, need a lack of ego; emotionalism is a drawback'. Patients spent more time discussing this theme than any other. They highlighted that they 'want caring and compassion, approachable, not cold, reassurance, and doctors who have time for patients'. According to patients, doctors should help you 'make hard decisions', 'be caring, down to earth, and give hope'. It was intriguing to note that 1 patient mentioned that the 'consequence of a lack of caring may be that patients do not seek medical advice when needed'.

The third primary theme, character virtues, includes a listing of all the positive characteristics we hear describing professionalism. All 4 groups emphasised compassion. Unique to faculty within this theme is the concept of maturity. Unique to residents is the

need to be decisive and succinct. Unique to patients is the expressed desire for the virtue of humour, the ability to show emotion, being down to earth and honesty.

Secondary themes

Secondary themes included medicine as a unique profession. All groups discussed the intensity of the issues which doctors must handle, especially those involving the beginning and end of life. Increasing emphasis on the spiritual and reverent side of medicine was expressed as one moved across the medical training continuum, with faculty using terms such as 'reverent trust' and 'spiritual angst'. Students recognised the higher standards to which doctors are held but did not express their opinions with the depth of feeling that was heard by the focus group leaders from the doctors.

The theme of personal congruence carried the message that the internal values of a doctor should match the external behaviour and actions. Faculty

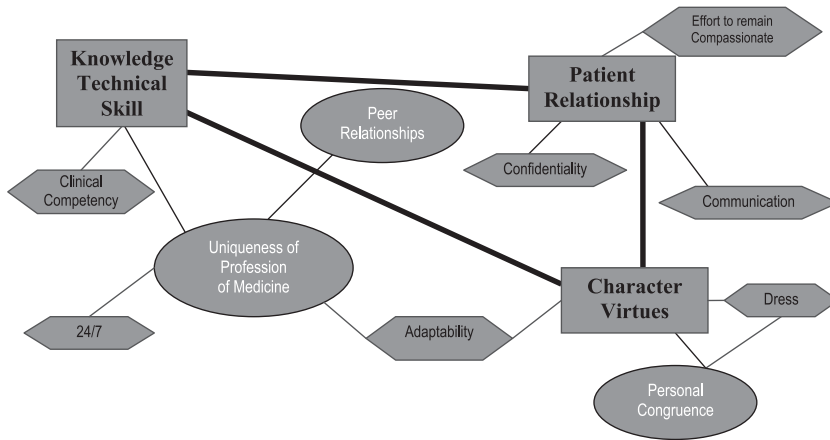


Figure 3 Resident professionalism map

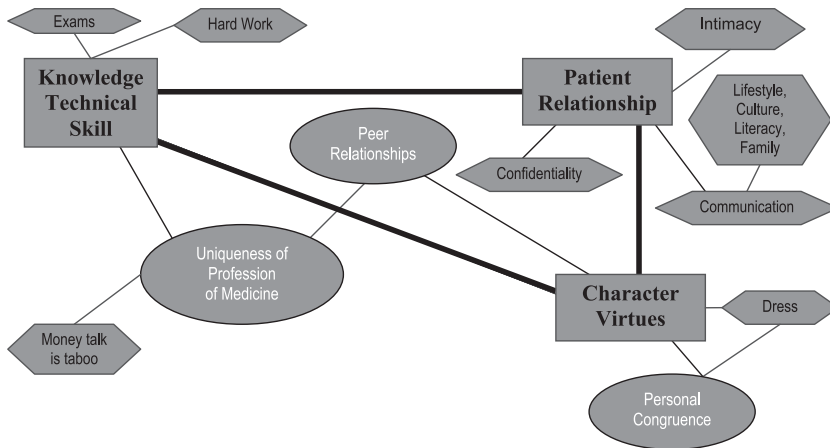


Figure 4 Student professionalism map

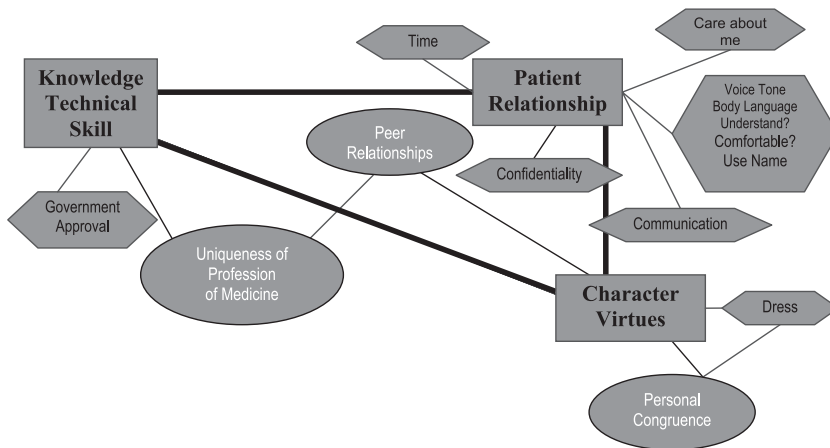


Figure 5 Patient professionalism map

emphasised that ‘true professionalism implies a consistency regardless of stress level’. ‘I mean you can dress people up, but you can’t make everyone a doctor.’ Patients expressed the naturalness of professionalism in some cases – ‘need to steer lost causes away from people’ and ‘when good qualities come naturally, those are the best docs’.

Finally, the theme of peer relationships was expressed most frequently by faculty and it was faculty who

expanded the peer group to include nurses, staff and colleagues. All other groups recognised the medical ‘team’; however, students, residents and faculty included the additional element that professionalism included fair treatment of medical colleagues.

Unique thematic elements by focus group type

Figures 2–5 present conceptual maps of themes discussed by faculty, resident, student and patient

groups. Within the faculty group we observe an emphasis on knowledge and technical skills that adds the value of life experience, dealing with stress and the power of resiliency. Faculty are also the group that emphasises the concept of duty and the concept of empowerment versus authoritarianism as it connects the doctor to the patient. Again, with faculty we find an emphasis on maturity, the importance of other staff members, the notion of reverent trust and spiritual angst. In addition, faculty discussed that patients may not be able to establish the doctor's areas of incompetence.

Unique elements from the resident perspective include the focus on decisiveness and being succinct. They also discussed the need to be available and adaptable 24 hours a day and 7 days a week. We see the rudiments of the concept of duty but it is peer-based duty, not patient-based. Again, perhaps reflecting their current role, residents spent time talking about 'beyond normal demands for compassion' and the fact that it takes effort to remain compassionate. As we view the maps, there appears to be a consistent shift from the knowledge side to increased detail on the patient and doctor side and on personal characteristics.

Students develop the part of the professionalism map that has to do with the relationship, bringing in elements of lifestyle, culture, literacy and family into the relationship and into the communication. They also discussed the fact that they may hurt someone, a concern that does not appear at the resident or faculty level. The majority of the conversation had to do with the beginning awareness of the reciprocity of the patient–doctor relationship and a corollary need that superior colleagues should respect students.

Student issues about the patient relationship are repeated and even developed to a greater depth by patients. Patients talk about being asked if they are comfortable, about body language, about voice tone. They want their names to be used. The level of detail becomes very specific, as the professionalism map of patients lives in the relationship corner. They say 'See me, hear me, feel with me' and 'be fair to all of us'. Knowledge and character virtues remain, but it all plays out in the relationship theme.

DISCUSSION

From these results we identified common elements of professionalism as viewed by medical learners along the training continuum and by patients. The com-

mon primary and secondary themes match some components of professionalism highlighted in the expert-created 'Medical professionalism in the new millennium: a physician charter'.¹¹ The theme of knowledge and technical skill is in accord with the Charter's commitment to professional competence and commitment to scientific knowledge. The patient relationship theme is reflected in the commitments to honesty, confidentiality and maintaining appropriate relationships expressed in the Charter. The character virtue theme, although not a specific element of the Charter, is certainly the underlying principle of all elements of commitment. Further, the theme of peer relationships is reflected in the Charter's commitment to professional responsibilities.

Of note, however, is a missing component in these focus groups in comparison to the Charter.¹¹ There was little mention of social justice elements reflected in the commitments to improving quality of care, access to care and assuring a just distribution of finite resources. Indeed, the concept of duty expressed only by residents and faculty was the closest element to these elements of professionalism established by experts. It is important to underscore that residents discussed duty to peers and only faculty discussed duty to patients. One might suggest that experience with the medical system is what leads to the necessity to include these elements in our approach to professionalism. Students and patients in our study do not mention social justice. Does this reflect naiveté, an inherent trust that someone is fairly dividing the resource pot, ignorance that access and resources are limited? Students mention specifically that one should not speak about the money and that medicine is not a business, and yet efficiency and cost-effectiveness are inherent elements in today's health system. These contrasting results suggest that it is these elements of professionalism that may be most difficult to teach without expanded curricular time and life experience.

These results also underscore the differences between the 4 types of groups. Differences appear reflective of the stage of learning at which the discussants are operating, including patients at a consumer stage. For example, faculty reflected on the need for maturity; residents for constant availability; students focused on the possibility of hurting someone; and patients express a keen desire to be heard. More globally, however, what is interesting is the shift of emphasis from the relationship side of the maps (observed in patients and students) to the knowledge

and skill side (observed in faculty and residents). The detail of interest moves. Faculty no longer dwell on specific elements of the relationship such as voice tone and health literacy. Words become more poignant and loftier such as 'spiritual angst'. The picture becomes bigger, with the knowledge and skill items less expressed. Perhaps it is a shift only in emphasis, with the skills becoming more tacit, more implicit and so understood that we no longer discuss them.

Observation of this shift could lead us to consider the target audience of true professionalism. Is it the patient? The doctor? The profession? Why are we concerned about professionalism? Is it not because of the impact that lack of professionalism would have on patient care? If the target of professionalism issues is the patient, then our focus groups of patients with the detail of discussion in the relationship may suggest that it is the patient's perspective we should emphasise in our search for professionalism. Thus relationship issues come to the foreground. Correspondingly, could we view part of our teaching mission as enhancement of the patient perspective by increased public forum and discussion of the missing themes of social responsibility and economic health care issues? As resources become increasingly limited, patient definitions may be required to move toward understanding the concepts of 'greater good' versus 'individual health'.

Limitations of the study include the use of learners and patients at a single institution, small sample size and the biases of these particular qualitative reviewers. Future studies may confirm the findings of common themes as well as unique differences between patients and providers and the developmental shifts across learning stages that were observed.

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