

# Assessment of Professionalism Project

## Purpose

The topic of professionalism is one that has occupied the agenda of the GEA for many years, and one that continues work begun with the Medical School Objectives Project (MSOP). The document that follows was developed to foster a consensus on a definition of professionalism across the continuum. The purpose of this document is to provide a resource, with specific examples and tools used to define and measure professionalism in medical practice.

## Introduction

The topic of professionalism has been at the top of the agenda of the Group on Educational Affairs (GEA) for many years. When the GEA was reorganized, four sections were created, in addition to the existing four regions. The reorganization evolved and there was a clear need to provide a context for the GEA Sections and Regions to work together on a project of mutual interest. The topic of professionalism, specifically the assessment of professionalism, was identified as an important area of work to pursue. Each GEA Section (undergraduate medical education, graduate medical education, continuing medical education, and research in medical education) identified two volunteers from each of the four GEA regions (northeast, southern, central, and western) to serve on a task force. Thus, there were eight members of each Section task force. Each Section task force reviewed the literature for articles about the assessment of professionalism in their domains. In addition to the published literature, documents that were known to task force members, were reviewed.

Each Section task force was charged to prepare a short paper that considered the following in their domains:

- Define professionalism in medicine
- Identify issues facing professionalism
- Review the available, published literature concerning professionalism and the assessment of professionalism
- Review the tools in use to assess professionalism
- Identify examples of how professionalism is taught at each level
- Identify examples of ways professionalism is assessed at each level
- Identify questions for continued research
- Determine next steps for implementation of concepts that arise from the review of the literature.

The draft document was organized into seven sections:

- a) introduction
- b) definition of professionalism
- c) the learning environment to foster professionalism and the inherent conflicts in the environment
- d) available tools for the assessment of professionalism at each level

- e) questions for further research
- f) next steps for implementation
- g) bibliography

The draft document was distributed to all four GEA regions and was the focus for discussion at each spring meeting. This draft incorporates suggestions, additions, and changes from each regional spring meeting. In addition, an eighth category was added to the document, based on regional meeting discussion - examples of how professionalism is taught at each level.

## **Definition**

The assessment of professionalism must begin with a shared definition of the knowledge, skills, and attitudes to be assessed. All four Sections used the article by Swick (1) to define medical professionalism. During the discussions of the draft document at the regional meetings, the definition was expanded to include medical professionalism as comprising the following sets of behaviors:

- Physicians subordinate their own interests to the interests of others;
- Physicians adhere to high ethical and moral standards;
- Physicians respond to societal needs, and their behaviors reflect a social contract with the communities served;
- Physicians evince core humanistic values, including honesty and integrity, caring and compassion, altruism and empathy, respect for self, patients, peers, attendings, nurses, and other health care professionals;
- Physicians exercise accountability for themselves and for their colleagues;
- Physicians recognize when there is a conflict of interest to themselves, their patients, their practice
- Physicians demonstrate a continuing commitment to excellence;
- Physicians exhibit a commitment to scholarship and to advancing their field;
- Physicians **must (are able to)** deal effectively with high levels of complexity and uncertainty;
- Physicians reflect critically upon their actions and decisions and strive for IMPROVEMENT in all aspects of their work
- Professionalism incorporates the concept of one's moral development
- The profession of medicine is a "self regulating" profession, dependent on the professional actions and moral development of its members; this concept includes one's responsibility to the profession as a healer
- Professionalism includes receiving and responding to critiques from peers, students, colleagues, superiors
- Physicians must demonstrate sensitivity to multiple cultures
- Physicians must maintain competence in the body of knowledge for which they are responsible; they must have a commitment to life long learning
- The AAMC's Medical School Objectives Project (MSOP) includes the attributes of altruism and dutifulness in the definition of professionalism of physicians.

## The Learning Environment

Several of the articles reviewed identify the need to resolve the conflict inherent in the philosophy of managed care policies and the ethical guidelines that shape the practice of medicine. A clash of values is described between major capitalistic values and major values of the medical profession. A model of professionalism is based on three core elements: devotion to medical service, public profession of values, negotiation regarding professional values and other social values. Physicians are called upon to advocate health care values rather than government or corporate values, speaking on behalf of their patients and health care. There must be an emphasis on the importance of professional behavior in the institution. Everyone must be accountable, using the same measures.

The articles reviewed advocate changes in the medical student learning environment. **Medical schools** should articulate and defend the importance of professional values. This extends to the environment of the institution where issues such as the presence of pharmaceutical representatives and issues of confidentiality may provide compromises to professionalism. The institution must foster an environment where critique is viewed as helpful and must recognize the problem of students' reluctance to provide negative feedback for peers. The medical school welcomes and acculturates future physicians into the profession. The medical school provides a fundamental base on which future education, professional development, and lifelong learning is built. These represent formative years and experiences. Learners are highly impressionable and learn vicariously in multiple social and organizational contexts from interactions with a wide range of individuals in increasingly diverse and rapidly changing environments.

In his article, Relman:

- a) lists subjects that should be included in the medical school curricula: social and political history of the U.S. medical profession as it evolved over two centuries;
- b) introduction to the economic dimensions of health care;
- c) history of health maintenance organizations;
- d) ethical, legal, and professional issues raised by the industrialization of health care; and,
- e) political and professional options for solving issues in a manner that would preserve the most important principles of medical professionalism while addressing the social objectives of cost control, quality control, community service, and universal access to care.

For every level of the educational continuum it is critical to responsibly align the values of the profession with societal needs.

**Residency programs** should require successful completion of approved courses directed by the medical profession and not by the health care industry. The approved courses should encompass the topics listed above for medical schools. A professional environment includes elements of confidentiality, particularly in the hospital setting, the role of the residents with medical students, and the concept of being non-judgmental of both patients and students.

**The CME community** must be involved in fostering professional and humanistic behaviors for faculty that can be modeled as the faculty prepare students to practice in a more competitive

health care environment. The practice environment must be included in the concept of professionalism, including the importance of the health care team.

In summary, learning environments must be structured so that professionalism is acknowledged and rewarded and unprofessional behavior results in negative consequences. Opportunities to demonstrate professionalism must be created and promoted.

### **Issues for consideration**

- Need to clarify the level of training – is the same expected of students, as of residents, as of practicing physicians?
- What constitutes having/being professional? (e.g., “7 of the following”)?
- Consider developing a “self assessment tool” for the institution’s culture/ the hidden curriculum

### **Tools**

Each of the Section task forces identified assessment tools, many of which may be applied to assessing the qualities defined as “professionalism”

A true evaluation of professionalism must focus on the reasons for a behavior, rather than just the behavior itself. Professional behavior assessment tools must take into consideration the contexts in which unprofessional behaviors occur, the conflicts that lead to lapses in behavior, and the reasons the choices were made. Assessment cannot rely on a single tool or approach.

Tools that exist include:

- Evaluations by faculty supervisors – rating forms are the most commonly used instrument and typically have one global “professionalism” item. The use of encounter cards (on a daily and/or weekly basis) has shown reasonable inter-rater reliability and construct validity. Faculty are frequently reluctant to provide feedback.
- Scales to rate professionalism by nurses and patients. This is very time consuming and requires multiple responses per resident and student, making it impractical.
- Peer evaluation – this is used by many of the MSOP consortium schools. The major drawback is the reluctance of students to provide negative feedback about fellow students.
- Self evaluation – most self assessment focuses on assessment of knowledge and skills, rather than professional behaviors.
- Standardized patients – the primary focus is on the assessment of clinical skills. Most studies have shown that as many as 41 stations would be required to achieve good reliability for assessment of professional behaviors
- Simulations – e.g., SPs (individual SPs, SP families) single events and longitudinal ?Announced versus Unannounced (latter is very, very complicated, logistically)
- Longitudinal observations – a longitudinal instrument that includes observation of problematic students across several rotations. Most systems include a component of

remediation and focus on unprofessional behaviors rather than labeling a student as unprofessional.

- Clinical vignettes – used to elicit responses from students and residents at different levels of training.
- There have been improvements in direct observations (clinical setting, PBL, labs), but these methods are costly and time consuming
- Ask Program Directors, 1.5 years after graduation, about the professionalism of their residents
- Retreat and/or focus groups with faculty and residents
- Retreats and/or focus groups with residents alone
- A Balint group or scenario that could be used across the continuum
- Include letters sent spontaneously in students', residents' folders as an assessment of their professionalism

The following were identified as “Promising Practices”- tools in use for which studies to determine their validity, reliability, and applicability are still in progress.

### **“Promising Practices”**

Knowledge assessments:

- Integrated MCQ items
- Hypermedia assisted assessment modules
- Patient-based scenarios and linked items
- Adaptive computer-based testing
- Portfolios
- Interviews/debriefings
- In-basket simulation-type assessments
- Video-based reviews
- Content analysis of posting (e.g., Virtual PBL)

Behavior/Skills:

- Virtual patient simulations (e.g., VPBL, L.I.V.E.)
- Hypermedia based patient problems
- Email – students as group practice interacting with Standardized Patient
- Practical exams
- Video reviews
- Portfolios
- Projects
- Document review (chart audits)
- Virtual simulations (e.g., surgical, medical procedures, physical examinations??)
- Client/patient feedback measurements
- Community based feedback (service involvement, community-based practices)

Affective/Attitudes/Values:

- Proactive or by exception – longitudinal protocol/student record and set procedures
- Self-report -- longitudinally

- Client/Patient feedback measurements
- Unannounced direct observations – how many over what period of time is enough
- Appropriateness of various formats for assessment – relationship to real-life, authentic expectations
- hypermedia assisted modules
- Content analysis of online interactions
- Log analysis in web-based environments (search intentions reflective of life long learning attitudes that are reflected in informatics objectives)
- specific behaviors in situ over what period of time, what sampling, from which inferences can be made about “can do” and/or “will do” or “chooses to do” (even when not being assessed) For example.....

SP interactions – announced? Unannounced?

- Peer assessments and reports (systematically/proactively or by exception?)
- Activity audits (e.g., community service, etc.)

*Complex/Combined knowledge, behaviors, attitudes/values assessments*

- Virtual modules
- Real-life observations (e.g., in community-based offices) – hidden videocam or using unannounced SPs (e.g., TAHC)
- Portfolios --- longitudinal across 4 years (w/ or w/o periodic debriefings) – PPVEME in 2000-2001
- Projects w/ or w/o debriefings
- Longitudinal SP assessments (simulations of real patient problems and follow-up) – students coop as group practices and interact w/fake HMO, etc.

### **Issues for consideration and further research**

- Are we treating behaviors and knowledge in the same manner? This concern should be addressed
- Include a written exam as a tool – determine whether students have the knowledge about professionalism to support their behaviors
- There is an anecdotal quality to the information and the examples...is there something available that is more definitive?
- There is an intrusive nature to the tools that is in conflict with the quality of having respect for “others” – has this been considered?
- Are the tools looking for a pattern of behaviors, or a single behavior or a single incident?
- Are there tools for students to evaluate faculty?

- Can the tool be applied across the continuum? How effective is it?
- Can these tools be applied to the admissions process?
- Develop/use tools to assess the environment (consider the business literature)
- Be sure it's clear that faculty includes residents, fellows
- Encourage reflective practice; encourage self reflection
- Incorporate due process as part of professionalism
- Professionalism must be separately evaluated and the consequences must be separate
- Focus assessment on reflection and improvement of entire profession – not simply to penalize
- “Good” professionalism is transparent - need to reinforce positive behaviors
- Assuming we can teach, or have impact on these behaviors, we need remediative approaches
- Should there be two separate lists? One of TOOLS to assess professionalism and One of Professional behaviors?

### **Examples of how Professionalism is Taught**

This section will be completed as the matrix is completed

### **Research Questions/Criteria for Evaluation of Instruments to Assess Professionalism**

- ◆ What are the components of the definition of professionalism?
- ◆ Is the definition of professionalism consistent with an accepted definition of professionalism?
- ◆ If it is a state, have developmental benchmarks been proposed?
- ◆ How is the definition informed by existing theory and literature?
- ◆ What is the relationship of the group who will apply the assessment tool to the group to whom it is applied?
- ◆ Is the purpose of the instrument to identify professionalism or unprofessional behaviors?
- ◆ What decision is to be made from information gathered by the instrument?
  - Feedback/summative/description
  - Rank order all takers or pass/fail

### **Criteria For Evaluation Of Instruments To Assess Professionalism**

- ◆ What is its purpose?

- ◆ What aspect of professionalism is it intended to measure? Knowledge, attitudes, behaviors?
- ◆ What is the sample size, location, and demographics?
- ◆ How are data recorded?
- ◆ How is it scored?
- ◆ Is it reliable?
- ◆ Is it valid?
- ◆ Were standards set/classifications made?
- ◆ What is the feasibility? Length, Cost?
- ◆ Do the data derived from the tool seem amenable to change?
- ◆ Does the tool educate users about the construct being assessed?
- ◆ What components of professionalism is this tool measuring?
- ◆ **Is professionalism a state or a trait?**
  - Is there an event that causes a student to exhibit a behavior?
  - Is the behavior a character trait?
  - Have we been CLEAR about expected behaviors?
  - Are there different thresholds for professionalism at different levels?
  - How much “bad” behavior is tolerable before one gets the label unprofessional?
  - Are there predictive measures for professionalism?
  - Are we assessing professionalism or personality?
  - What is the public’s view of professionalism?
  - What are other health care professionals’ views of professionalism?
  - Is the tool USEFUL?

The items identified were put into a matrix (attached) and the cells of the matrix will be filled in as the tools and supporting literature are identified. For those cells left blank, work is underway, particularly in the GME and UGME sections to develop necessary tools.

There is still considerable work to be done with this project. Some of the next steps include the following.

- ◆ Create a specific set of goals to be achieved by a student, a resident in training, and a practicing physician in the area of professionalism.
- ◆ Make recommendations concerning the appropriate professional learning environment necessary to model professional behaviors during student and residency training.
- ◆ The RIME section can begin the process to assure the instruments used are valid and reliable.
- ◆ The UGME section has begun to collect and annotate a series of articles (many of which are included in the bibliography appended to this document). An example of the annotated bibliography is attached.

Following is an example of the types of information being collected by the UGME Section. More may be found on the UGME website at:

[www.aamc.org/members/gea/ugmesection/ugmeevaluations](http://www.aamc.org/members/gea/ugmesection/ugmeevaluations)

Undergraduate Medical Education (UGME) Section  
Professionalism References: Critical, Annotated Bibliography

Arnold, EL, Blank, LL. Et al. (1998). Can Professionalism Be Measured? The Development of a Scale for Use in the Medical Environment. *Academic Medicine*. 73:1119-1121.

Type of Report / Study: Scale Development  
Population / Application: Medical Students  
Instrument Title: Scale to Measure Professional Attitudes and Behavior  
Type (Method) of Assessment: Questionnaire  
Indicators and Scale: Agreement Scale  
Traits / Competencies Assessed: Excellence, Honor/Integrity, and Altruism/Respect  
Reliability/Validity Data: Chronbach's Alpha: Eignevalues  
Conclusion: First step in the development of a scale that can measure components of professionalism. Internal reliability and item-scale coefficients are moderately high.  
Comments: Excellence scale appears particularly strong

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## Bibliography

Swick, HM Toward a Normative Definition of Medical Professionalism. *Academic Medicine* 2000; 75: 612-616.

American Board of Internal Medicine, Committee on Evaluation of Clinical Competence. Project Professionalism. ABIM, Philadelphia: 1995.

ACGME. Outcomes Project. ACGME General Competencies Vers. 1.3 (9.28.99)

Markakis, KM, Beckman, HB, Suchman, AL, Frankel, RM. The Path to Professionalism: Cultivating Humanistic Values and Attitudes in Residency Training. *Academic Medicine* 2000; 75: 141-150

Reynolds, PP. Reaffirming Professionalism Through the Education Community. *Annals of Internal Medicine*. 1994; 120: 609-614.

Ramsey, PG, Carline, JD, Inui, TS, Larson, EB, LoGerfo, JP, and Wenrich, MD. Predictive Validity of Certification by the American Board of Internal Medicine. *Annals of Internal Medicine*. 1989; 110; 719-726.

Carline, JD, Wenrich, MD, Ramsey, PG. Characteristics of Ratings of Physician Competence by Professional Associates. *Evaluation and the Health Professions*. 1989; 12: 409-423.

Ramsey, PG, Carline, JD, Inui, TS, Larson, EB, LoGerfo, JP, and Wenrich, MD. Assessment of the Clinical Competence of Certified Internists: Final Report to the ABIM. Seattle: University of Washington, June 1990.

Ramsey, PG, Carline, JD, Inui, TS, Larson, EB, and LoGerfo, JP. Use of Peer Ratings to Evaluate Physician Performance. *Journal of the American Medical Association*. 1993; 269: 1655-1660.

Arnold, EL, Blank, LL, Race, KE, and Cipparrone, N. Can Professionalism be Measured? *Academic Medicine*. 1998; 73: 1119-1121/

Shea, JA, Bellini, LM, Reynolds, EE. Assessing and Changing Unprofessional Behaviors Among Faculty, Residents, and Students. *Academic Medicine*. 2000; 75: 512

Ginsburg, S., Regehr, G., Hatala, R., McNaughton, N, Frohna, A, Hodges, B., Lingard, L. and Stern, D. Context, Conflict, and Resolution: A New Conceptual Framework for Evaluating Professionalism. *Academic Medicine*. 2000; 75: S6-11.

Woolliscroft, J – Assessing Professional Values; Values on Call: A Method for Assessing the Teaching of Professionalism. *Academic Medicine* 1996: s37-39

Ludmerer, K. Instilling Professionalism in Medical Education, *Journal of the American Medical Association*, September 1, 1999. P. 881

Epstein, R. Mindful Practice, *JAMA*, September 1, 1999, p. 833.

Rothman, D., Medical Professionalism Focusing on Real Issues. *The New England Journal of Medicine*, April 27, 2000, p. 1284.

Bossers, A., Kernaghan, J., Hodgins, L., Merla, L., O'Connor, C., and Van Kessel, M. Defining and Developing Professionalism; *Canadian Journal of Occupational Therapy*, June 1999. , p. 116.

Wynia, M., Latham, S., Kao, A., Berg, J., Emanuel, L. Medical Professionalism in Society. *The New England Journal of Medicine*. November 18, 1999, p. 1612.

Relman, A., Education to Defend Professional Values in the New Corporate Age. *Academic Medicine*, December 1998, p. 1229.

Barry, D., Cryan, E., and Anderson, R. Common Issues in Medical Professionalism: Room to Grow, *The American Journal of Medicine*, February 2000, p. 136

Cruess, S, Cruess, R., and Johnston, S. Renewing Professionalism: An Opportunity for Medicine, *Academic Medicine*, August 1999, p. 878

Pellegrino, E. and Relman, A. Professional Medical Associations *JAMA*, September 8, 1999, p. 984

Sullivan, W. "What is Left of Professionalism in Managed Care". Hastings Center Report, March/April 1999, p. 7

Swick, H., Szenas, P., Danoff, D., and Whitcomb, M. Teaching Professionalism in Undergraduate Medical Education, *JAMA*, September 1, 1999, p. 830

Frankford, D., Patterson, M., and Konrad, T. Transforming Practice Organizations to Foster Lifelong Learning and Commitment to Medical Professionalism. *Acad. Med.*, July 2000, p. 708

Swick, H. Academic Medicine Must Deal with the Clash of Business and Professional Values, *Acad Med*, July 1998, p. 751.

Papadakis, M., Osborn, E., Cooke, M., and Healy, K. A Strategy for the Detection and Evaluation of Unprofessional Behavior in Medical Students. *Acad. Med.* , September 1999, p. 980

Mellinkoff, S. Time to Heal and the Future of U.S. Medical Education, *Acad. Med.*, October 1999, p. 1061

Markakis, K., Beckman, H., Suchman, A., and Frankel, R. The Path to Professionalism: Cultivating Humanistic Values and Attitudes in Residency Training *Acad Med*, February 2000, p. 141

Hemmer, P., Hawkins, R., Jackson, J., and Pangaro, L. Assessing How Well Three Evaluation Methods Detect Deficiencies in Medical Students' Professionalism in Two Settings of an Internal Medicine Clerkship *Acad Med* February 2000, p. 167

Cohen, J. Measuring Professionalism: Listening to Our Students *Acad Med*, September 1999, p. 1010

"Ethics Manual". Members of the Ethics and Human Rights Committee for the 1996-97 and 1997-98 terms. *Annals of Internal Medicine*, April 1998

Freeman, V. Rathore, S., Weinfurt, K., Schulman, K., and Sulmasy, D. Lying for Patients. *Arch Internal Med*, October 25, 1999, p. 2263

Wear, D and Castellani, B. The Development of Professionalism: Curriculum Matters. *Acad Med*, June 2000, p. 602