

# Viewpoint: Today's Professionalism: Engaging the Mind but Not the Heart

Jack Coulehan, MD

## Abstract

Professionalism is a current in medicine today, but the movement to teach and evaluate professionalism presents a conundrum to medical educators. Its intent is laudable: to produce humanistic and virtuous physicians who will be better able to cope with and overcome the dehumanizing features of the health care system in the United States. However, its impact on medical education is likely to be small and misleading because current professionalism curricula focus on lists of rules and behaviors. While such curricula usually refer to virtues and personal

qualities, these are peripheral because their impacts cannot be specifically assessed.

The author argues that today's culture of medicine is hostile to altruism, compassion, integrity, fidelity, self-effacement, and other traditional qualities. Hospital culture and the narratives that support it often embody a set of professional qualities that are diametrically opposed to virtues that are explicitly taught as constituting the "good" doctor. Young physicians experience internal conflict as they try to reconcile the explicit and covert curricula,

and they often develop nonreflective professionalism. Additional courses on professionalism are unlikely to alter this process. Instead, the author proposes a more comprehensive approach to changing the culture of medical education to favor an approach he calls narrative-based professionalism and to address the tension between self-interest and altruism. This approach involves four specific catalysts: professionalism role-modeling, self-awareness, narrative competence, and community service.

Acad Med. 2005; 80:892–898.

**H**. L. Mencken wrote, "There is always an easy solution to every human problem—neat, plausible, and wrong."<sup>1</sup>, p. 442 This applies to today's project to instill "professionalism" in medical education. I believe the movement to teach and evaluate professionalism in medical training is threatened with failure because the intervention is too simple, too neat, too flimsy, and doesn't engage the problems it attempts to address. These problems, as I conceive them, are both internal and external to the profession. Internally, the medical community suffers from depleted moral imagination, while vast numbers of its individual practitioners suffer from existential conflict and timidity of response. Externally, the profession is beset on all sides by the disappointment, dissatisfaction, and misunderstanding of the people whom it is supposed to serve. So yes, professionalism in medicine does appear to be in bad shape; but no,

Professionalism—with a capital "P," indicating the Simple Answer—will not revive it.

In this essay I present a series of reflections on today's culture of medicine and medical education, with particular emphasis on the V-word: virtue. I want to address the issue that Larry Churchill raised more than 15 years ago, "How did we get to this point of not valuing a distinctive professional ethic? A profession without its own distinctive moral convictions has nothing to profess."<sup>2</sup>, p. 34 If indeed we as medical educators have nothing to profess, then an aggressive program to instill and promote a code of professional behavior in physicians-in-training will be artificial and bound to fail. In place of professionalism, I want to suggest a more comprehensive approach to a rebirth of medical morality for the 21<sup>st</sup> century.

### The Recent History of Professionalism

By the early 1970s, biomedical ethics, which focuses mostly on patient rights and the structure and process of shared decision making, had replaced old-fashioned professional ethics in medical education. Many believed that professional ethics, based on virtue and duty, had confined itself to the special

interests and obligations of physicians.<sup>2–6</sup> In fact, the discipline had acquired a bad reputation as being more a set of rules to protect the interests of physicians than a code of moral conduct to protect patients. A few biomedical ethicists developed a new approach to morality from the old vantage point of professional virtue,<sup>7–11</sup> but their works tended to lack the edge and bite of "hard" ethics and rarely served as the meat and potatoes of ethics teaching. In teaching about the "good" doctor, we focused on talking the talk (ethics courses) and assumed that walking the walk (following in the footsteps of exemplary physicians) would take care of itself; i.e., physicians-in-training would acquire professional values by osmosis from mentors and role models as they progressed through their training, just as generations of physicians had presumably done in the past.

In 2005, the situation has changed dramatically. Today, the term "professionalism" springs like kudzu from every nook and cranny of medical education. In the last few years, the Association of American Medical Colleges (AAMC), the Accreditation Council for Graduate Medical Education, the American College of Physicians, and other organizations have generated major initiatives to teach professionalism as a core competency in medicine and also to

**Dr. Coulehan** is professor, Division of Medicine in Society, Department of Preventive Medicine, Health Sciences Center, School of Medicine, Stony Brook University, Stony Brook, New York.

Correspondence should be addressed to Dr. Coulehan, HSC L3-086, Health Sciences Center, School of Medicine, Stony Brook University, Stony Brook, NY 11794-8036; telephone: (631) 444-9744; fax: (631) 444-8029; e-mail: (jcoulehan@notes.cc.sunysb.edu).

require that educators measure the outcome of their efforts.<sup>12–17</sup>

Why have we resurrected this explicit focus on “a distinctive professional virtue”? Let me present my own view of the forces that medical educators have been obliged to respond to, in order to meet their goal of producing highly competent and ethical professionals. Over the past several decades, medicine in the United States has evolved into a vast, increasingly expensive technological profit center, in which self-interest is all too easily conflated with altruism. While medical treatment became more efficacious than ever before, it also became potentially more harmful to patients. As technology advanced, patients developed higher expectations of cure, but at the same time they became progressively less satisfied with the personal aspects of medical care. While specialists spent more time wielding the mighty machine, they spent less time listening to or connecting with their patients. Meanwhile, commercialism began to run rampant in medicine, including the rapid development of for-profit hospital systems and managed care organizations and the appearance of a vast array of opportunities for physicians to make money from commercial relationships, especially with pharmaceutical companies. Commercialism set the stage for increasing conflict between the interests of physicians and their patients. The costs of the system skyrocketed, but it nonetheless remained inequitable and inaccessible to significant segments of the population. The evolution of applied science was not accompanied by the evolution of a legal right to health care. Yet our lingering cultural belief in equitable and relationship-based medicine haunts us and casts a pall over today’s machine-based medical practice.

As these problems developed, medical educators, far from ignoring them, responded with several generations of well-intended solutions that aimed to integrate the knowledge, skills, and attitudes of good doctoring into this new technological environment. Early innovations included creating the specialty of family medicine, formulating a so-called new paradigm for whole-person medicine (the biopsychosocial model), adding new skills to the curriculum (e.g., courses in

communication, humanities, and biomedical ethics), and adopting more creative methods of teaching (e.g., problem-based learning). More recently, the evidence-based medicine movement has provided a means of cutting through the information-dense background to teach physicians to make more scientifically based clinical decisions, and, hence, to make patient care more beneficial. Still, the situation did not appreciably improve; while the *minds* of our students became sharper than ever, their *hearts* appeared to be listless, and their moral compasses adrift. At this juncture, educators adopted an entirely “new” tack, which in essence is a return to pre-1970s professional values; that is, they began insisting that professionalism itself be taught and evaluated.

In medicine, professionalism “requires the physician to serve the interests of the patient above his or her self-interest. Professionalism aspires to altruism, accountability, excellence, duty, service, honor, integrity and respect for others.”<sup>18</sup>, p. 5 This definition includes conduct (serving), aims (aspiring), and virtues or qualities (altruism, etc.). Note that these terms refer to different but intrinsically related aspects of human functioning. Ideally, conduct arises from aims, which, in turn, are conditioned by qualities. For young physicians to become more humane and effective healers, they must demonstrate professional conduct, which they are unlikely to do unless their education also explicitly nourishes motivation and virtue. My criticism of the professionalism movement is that, in the attempt to render professionalism more quantifiable, it may use skills and practices as surrogates for virtue. Becoming a physician involves *witnessing*, and not just behaving. To the extent that professionalism becomes a list of required practices, it is an example of H. L. Mencken’s neat and simple, but wrong, solution.

### The State of the Art

The tradition of medical professionalism holds that there are deeply held values internal to the goals of the profession, a commitment to moral behavior grounded in “that which I hold most sacred” (to quote a contemporary version of the Hippocratic Oath), and, as a result of sharing these values and beliefs, a strong sense of community identity in

medicine. Values, beliefs, and community are thus essential components of medical professionalism. But unless manifest in the lived experiences—the stories or narratives—of physicians, they are mere academic abstractions, like the bioethical principles of autonomy and beneficence. For medical professionalism to mold the behavior of physicians-in-training, it must be articulated as a meta-narrative that has developed over 2,500 years as a summation of, and reflection upon, many thousands of actual physicians’ stories from different times and cultures. Trainees must also experience professionalism as a bundle of contemporary narratives, either observed directly through role-model physicians and other health professionals, or indirectly through stories and film. In other words, to learn professionalism is to enter into a certain kind of narrative and make it one’s own.

I will use the term *narrative-based professionalism* to refer to this tradition, contrasting it with *rule-based professionalism*, which is the term I’ll use to describe the sets of objectives, competencies, and measurable behaviors that attempt to capture the concept of professionalism, but without focusing on its narrative ethos. I believe this dichotomy has heuristic value, although obviously neither “type” exists in pure form. My claim is that, given the current state of medical education, professionalism curricula are more likely to continue to move in the direction of lists of acceptable behaviors than to embody the full narrative tradition. To explain what I mean by this, let me describe briefly the texture of a medical trainee’s experience as it relates human values and professionalism.

### Tacit versus Explicit Learning

Many observers have described a conflict between what we think we are teaching medical students and young physicians (the explicit, or formal, curriculum) and a second set of beliefs and values that they learn from other sources (the tacit, informal, or hidden curriculum).<sup>19–29</sup> This conflict begins during students’ preclinical education and becomes more pronounced in the hospital and clinic. As students and house officers wend their way through years of training, they gradually adopt the medical culture and its value system as their own. An

important aspect of this socialization is the transfer, to trainees from their role models, of a set of beliefs and values regarding what it means to be a “good” physician.

The explicit component of professional development includes courses, classes, rounds, advice, or other teaching designed to instill professional values. Tacit learning, by contrast, includes the learning and socialization processes that instill professional values and identity without explicitly articulating those issues. This hidden curriculum continues throughout medical training. While the explicit curriculum focuses on empathy, communication, relief of suffering, trust, fidelity, and pursuing the patient’s best interest, in the hospital and clinic environment these values are largely pushed aside by the tacit learning of objectivity, detachment, self-interest, and distrust—of emotions, patients, insurance companies, administrators, and the state.

### The Hospital Narratives

Culture consists of the matrix of stories, symbols, beliefs, attitudes, and patterns of behavior in which we find ourselves. With this in mind, I want to propose a mental experiment and ask the reader to immerse her- or himself in a contemporary teaching hospital. Once there, listen to the conversations among physicians and between physicians and other health professionals. Pay close attention to the texture of hospital practice, in particular to its oral culture, the stories that surround you. What sort of stories are they? How can they be categorized? Which of the narratives appear to be especially meaningful to their narrators and audiences? In what ways do they fit together? What do these stories teach about what it means to be a good physician? In other words, in what moral universe does clinical education take place?

The first surprising observation you may make is that the vitality of this universe is centered outside the patient room. The narrative world is most alive in the teaching hospital’s hallways and conference rooms and unit stations. Generally, you discover that physicians enter their patients’ rooms as infrequently as possible; and when they do enter, they listen to these patients as

little as possible. Instead, they usually have an agenda in mind—a procedure to perform or a parameter to check. Their one-to-one interactions appear to play only a small role in shaping the “received wisdom” of hospital culture. In fact, procedures performed *on* patients are more frequently the starting place for the stories doctors tell one another than are their conversations *with* patients.

The second interesting feature is that stories permeating the hospital ethos don’t usually have patients as their active protagonists. Rather, patients serve as clever or frustrating or even stupid plot devices—presenting obstacles or challenges that may impair the story’s progress or, alternatively, pleasing foils or surprising twists that facilitate the story’s successful resolution. Nonetheless, the *real* protagonists or heroes of these stories are usually doctors, although in an increasing percentage of narratives the doctors may play second fiddle to cyborgs, i.e., machines of one sort or another that figure things out and set them straight.

With regard to villains, hospital narratives are considerably more varied. In some cases, the villain may be an impersonal negative force—a virus or accident, for example—which hardly qualifies as a villain at all. But in more complex cases, other health professionals may play the role of villains; for instance, the arrogant subspecialist, the power-hungry surgeon, the incompetent nurse, the stupid medical student, and so forth. Moreover, the patient’s own family may play a malevolent role, either as a result of being present (e.g., the hostile, questioning daughter) or being absent (e.g., the son who never shows up). Finally, patients themselves may take on the role of Bad Guys, with scripts that that demonstrate ignorance, anger, and—above all—noncompliance. In addition, patients play another important role in hospital stories, as the butt of gallows humor.

From an emotional perspective, many hospital stories about patients feel rather flat, even though at the same time these stories are intellectually stimulating. Embedded within them are extraordinarily complex puzzles: diagnostic dilemmas and physiological conundrums. These quandaries share certain characteristics with crossword

puzzles (find the correct word), jigsaw puzzles (fit the pieces together), and other games that require speed, endurance, and excellent hand-eye coordination. Nonetheless, the stories are two-dimensional because they contain little emotional resonance.

Yet the lack of emotional resonance in patient-and-doctor stories does not extend to interactions among students and hospital staff. Most of the feelings in medical culture that do get acknowledged are those of doctors or other health professionals, which tend to be expressed in negative attitudes and outbursts: “This place sucks!” “That gomer in 1215 is a real pain in the ass.” “I’m so pissed off at that resident I could scream.” Although expressions like these are permissible, the physician ethos in general disapproves of emotion and favors stoic acceptance. This, in fact, is one way that doctors demonstrate the superiority they feel over patients, who are often emotional and let subjective perspectives get the best of them.

Finally, as should be obvious, the virtues and values articulated in this thumbnail sketch of hospital culture bear little relationship to the traditional ethos and morality of medicine. If you accept this culture, you say self-interest whereas I say altruism. You say the patient is an object of interest; I say the patient is a subject of respect. You say the bottom line is to free up the bed; I say the goal is to promote healing.

This glimpse that I’m presenting of the world in which medical students and young physicians find themselves is a gross overgeneralization. First, it ignores the narratives of nursing, social work, chaplaincy, and many other professions. These professions, of course, overlap, reverberate with, and influence one another but—and this is quite remarkable—they seem to influence the culture of medicine very little. While physicians in the hospital are completely dependent on multiple other professionals and support personnel, the culture of medicine itself remains rather isolated and uninfluenced by them. Second, nowadays a substantial proportion of medical education takes place in clinic and office settings, where patient narratives may play a larger role in trainees’ overall experiences. Finally, I’ve overgeneralized about physicians

themselves. Fortunately, patients and their physicians also tell vibrant and edifying stories, and many residents and students repeat them and learn from them. Hospital culture is by no means entirely hostile, and many trainees graduate from it having cultivated positive and caring professional identities.

### The Varieties of Professionalism

However, the generalizations and value conflicts I have described do exist and do affect the outcomes of medical education. Peter Williams and I have argued elsewhere that such conflict between tacit and explicit values seriously distorts medical professionalism.<sup>26–28</sup> At an experiential level, medical students and house officers relieve or resolve their internal conflict by adopting one of three styles of professional identity.

- A *technical* professional identity, in which young physicians abandon traditional values and adopt a view of medical practice consistent with hospital culture. They become cynical about duty, fidelity, confidentiality, and integrity; and question their own motivation and that of others, thereby narrowing their sphere of responsibility to the technical arena.
- A *nonreflective* professional identity, in which physicians consciously adhere to traditional medical values while unconsciously basing their behavior, or some of it, on opposing values. In this type of self-delusion, a young physician believes that when she acts in accordance with hospital culture, she actually manifests the explicit values she learned in the classroom, although instead it is the hidden, negative values that are being expressed. For example, compassion is best manifested by detachment, and personal interaction is suspect because it lacks objectivity.
- A *compassionate and responsive* professional identity, adopted by a third, substantial group of young physicians, who thereby overcome the conflict between tacit and explicit socialization.

Let me emphasize that these characterizations represent the physician's internalization of what being a good doctor means and the manner in which he or she should behave. As such, they cut-across my rule-based and

narrative-based categories, which refer to the manner in which professionalism is conceptualized and taught by medical educators.

Williams and I claim that a large percentage of our graduates are best characterized as nonreflective professionals; that is, physicians who believe that they embody virtues like fidelity, self-effacement, integrity, compassion, and so forth, while acting in ways that not only conflict with these virtues, but also contribute to contemporary problems in health care such as rising costs, inadequate physician–patient communication, and widespread dissatisfaction. It is this group of physicians that most clearly exemplifies Albert Jonsen's insight about the core dynamic of professionalism, "The central paradox in medicine is the tension between self-interest and altruism."<sup>30</sup>, p. 7

### A Flag in the Wind

Thomas Inui's report, "A Flag in the Wind: Educating for Professionalism in Medicine," which is based on his experience as scholar-in-residence at the AAMC,<sup>31</sup> presents a systematic and comprehensive analysis of our continued failure to instill professional virtue in medical education. Because Inui's eight conclusions parallel my argument, I want to summarize them here. First, "the major elements of what most of us in medicine mean by professionalism have been described well, not once but many times."<sup>31</sup>, p. 4 This is understandable because these elements are based upon "the attributes of a virtuous person," about which there is widespread consensus. Next he observes, however, that the literature and rhetoric of medicine fail to grasp "the *gap* between these widely recognized manifestations of virtue in action and *what we actually do*" in medical education and practice.<sup>31</sup>, p. 4 Inui acknowledges that physicians "may be unconscious of some of this gap" but when they are conscious of it, they tend to be "silent or inarticulate about the dissonance."<sup>31</sup>, p. 4

In his fifth conclusion, Inui draws attention to the discrepancy between "what they see us do" (the hidden curriculum) and "what they hear us say" (the formal curriculum). Under these circumstances, "students become cynical about the profession of medicine—

indeed, they may see cynicism as intrinsic to medicine."<sup>31</sup>, p. 5 In this context, "additional courses on medical professionalism are unlikely to fundamentally alter this regrettable circumstance. Instead, we will actually have to change our behaviors, our institutions, and ourselves."<sup>31</sup>, p. 5 Finally, Inui indicates that the most difficult challenge of all is for students and educators to understand that medical education is "a special form of personal and professional *formation*" (emphasis added), rather than a species of technical learning.<sup>31</sup>, p. 5

Inui recognizes that the gap between belief and behavior that characterizes our teaching hospitals is partly unconscious. To the extent that this is true, these physicians manifest nonreflective professionalism; that is, in the formation of their professional identities, they have internalized the belief that certain nonvirtuous behaviors are virtuous, since they are "the way things are in medicine." The term "nonreflective" implies that these physicians rarely, if ever, step back and consider the impact of their behavior on themselves and others, as human beings deserving of care and respect. Inui suggests that another part of the institutional gap between belief and practice is conscious and, therefore, hypocritical. Unfortunately, physicians with little interest in the narrative and value dimensions of medicine may at times be required to serve as teachers—and presumably role models—because of the infrastructure and demands of medical education. When these physicians impart their rote "wisdom," they do so hypocritically. Trainees quickly detect this and respond with cynicism.

### Narrative-Based Professionalism

To nurture the professional virtue, or narrative-based professionalism, that I am advocating, Inui observes that "we will actually have to change our behaviors, our institutions, and our selves."<sup>31</sup>, p. 5 In the educational culture that I've described, the prospects for such change seem bleak; yet I believe that cultural change is possible, given the right catalyst and sufficient receptivity in the medical community. I believe that receptivity among medical educators is growing, given their dissatisfaction with the processes and products of

professionalism education. As to the right catalyst, I will suggest four interrelated educational requirements that could provide a basis for the formation of a new medical morality in the 21<sup>st</sup> century. In proposing this framework, I am drawing upon the ideas of others, especially my colleagues in the fields of reflective practice and narrative medicine, whom I cite below. Moreover, as a means of evaluating a trainee's performance as he or she progresses through the process of learning professional virtue, I proposed another borrowed idea, the educational portfolio.<sup>32–35</sup> Such a portfolio is a collection of material assembled over time that provides evidence of learning and achievement. A medical trainee's portfolio might be structured to address specific competencies and include, for example, formal papers, case reports, extended patient narratives, descriptions of critical incidents, reflective writing, and self-assessment.<sup>36</sup>

### Professionalism role-modeling

*The first requirement for a sea change in professionalism is to increase dramatically the number of physicians who are able to role-model professional virtue at every stage of medical education.* By this I mean full-time faculty members who exemplify virtue in their interactions with patients, staff, trainees, and the community at large; who have internalized a broad, humanistic, and narrative perspective; and who are willing to forego high income in order to teach. These physicians eschew commercial entanglements. Because such physicians are reflective, as opposed to nonreflective, in their professionalism, their presence would dilute and diminish the conflict between tacit and explicit values, especially in the hospital and clinic. Such physicians communicate honestly and directly with trainees, who are likely to "get" the message because it comes from the heart. With the incorporation of more such faculty, the teaching environment would contain fewer mixed messages, where, for example, the voice says "engage" while the behavior says "detach." What trainees need is time and humanism. However, such faculty members cannot pay for themselves, and this implies major new financing for medical education.

### Self-awareness

*The second prerequisite for developing narrative-based professionalism is to*

*provide, throughout medical school and residency, a safe venue for students and residents to share their experiences and enhance their personal awareness.* Doctors need to understand their own beliefs, feelings, attitudes, and response patterns. One of the earliest proponents of this view was the British psychiatrist Michael Balint, who encouraged physicians to meet regularly in small groups to discuss difficulties with patients and their personal reactions to practice.<sup>37</sup> Physicians tend to view emotions as negative or disruptive, and often confuse intellectualizing their responses (naming an "affect") with genuine emotion.<sup>38</sup> Physicians are particularly vulnerable to anxiety, loneliness, frustration, anger, depression, and helplessness when caring for chronically or terminally ill patients.<sup>39</sup> They often try to cope with these emotions by suppressing or rationalizing them. The more effectively physicians reverse this process by developing self-awareness, the more likely they will have the resources to connect with, and respond to, their patients' experiences.

In addition, the trainee's moral development may be hindered by everyday learning situations. These include conflicts between the requirements of medical education and those of good patient care, assignments that entail responsibility exceeding the student's capabilities, and personal involvement in substandard care. Once again, the opportunity to discuss, analyze, critique, and sometimes repair these situations allows students to find their own voice and may eventually empower them to develop that voice effectively.<sup>40–43</sup>

### Narrative competence

Medical practice is structured around narrative—between physician and patient, teacher and student, and the like. However, as a result of the tension between explicit and tacit values, students learn to objectify their patients and devalue subjectivity. In part, they learn to conceptualize their patients in terms of flow sheets, rather than personal stories. At the same time, they internalize hospital narratives, which tend to be cynical, arrogant, egotistic, self-congratulatory, and highly rationalized, but nonetheless become influential in the formation of the trainee's professional persona. Moreover, students immersed in these stories have little time to listen to, and may also lack the skill to understand

and respond to, their patients' stories, or to experience themselves as characters in the larger narrative of professionalism in medicine.

Accordingly, *the third prerequisite for fostering narrative-based professionalism is the development of narrative competence.* This can be understood as "the ability to acknowledge, absorb, interpret, and act on the stories and plights of others."<sup>44</sup> The narrative medicine movement provides a way of reframing the knowledge, skills, and attitudes of good doctoring under the aegis of language, symbol, story, and the cultural construction of illness.<sup>45–50</sup> It draws upon the centrality of clinical empathy in establishing and maintaining therapeutic relationships, and also upon the broader, more imaginative empathy that allows observers to "connect with" the experience of persons not immediately known to them, such as the uninsured in Appalachia, HIV-infected children in South Africa, or refugees in Sudan.<sup>51–55</sup>

The trainee's own life experience, molded by positive role-modeling and reflective practice, serves as the basic material from which narrative competence may develop. However, students may enhance their repertoires of life experience by exposure to the written, filmed, and oral narratives of real and fictional physicians; and they may increase awareness of their own developing professional identities by writing personal and professional narratives consistently and with discipline.<sup>56–61</sup>

### Community service

*Finally, in order to teach narrative-based professionalism, the medical curriculum must include socially relevant service-oriented learning.* Interaction with patients in the hospital or office setting is insufficient to provide students and young physicians with narratives of interdisciplinary practice, biopsychosocial modeling, and social responsibility. The American Medical Association's Code of Ethics specifies in section VII that "A physician shall recognize a responsibility to participate in activities contributing to an improved community."<sup>62</sup> In section III, the Code of Ethics indicates that "A physician shall . . . recognize a responsibility to seek changes in (legal) requirements which are contrary to the best interests of the patient."<sup>62</sup> These manifestations of

professional virtue need to be addressed in medical education.

Service learning may operate on many different geographic and social levels, from activities that take place locally to those on a national or international level. Moreover, the focus may include students contributing to clinical care (e.g., working at free clinics, doing clinical work in third-world countries), public health work (e.g., vaccinating migrant workers, assisting in “Stop Smoking” campaigns), health education (e.g., participating in HIV education in local high schools, speaking at church groups and community organizations), community service (e.g., volunteering in local agencies or with groups that provide direct assistance to third-world countries), and political action on health and welfare issues.<sup>63–70</sup> Whatever the specific tasks involved, the minimal required “dose” of community service must be sufficiently large for students to view it as integral to the culture of medical education, rather than an unconnected add-on.

## Conclusions

Professionalism is a current in medicine today, but the movement to teach and evaluate professionalism presents medical educators with somewhat of a conundrum. Its intent is laudable: to produce humanistic and virtuous physicians who will be better able to cope with and overcome the dehumanizing features of the health care system in the United States. However, the impact of this movement on medical education is likely to be small and misleading unless it directly confronts the “central paradox in medicine,” which is the “tension between self-interest and altruism.”<sup>30</sup>

In many ways, today’s culture of medicine tends to be hostile toward altruism, compassion, integrity, fidelity, self-effacement, and other traditional qualities. In fact, hospital culture, and the narratives that support it, implicitly identify a very different set of professional qualities as “good,” and sometimes these qualities are diametrically opposed to the virtues that we explicitly teach. Students and young physicians experience internal conflict as they try to reconcile the explicit and covert or hidden curricula, and in the process of their professional character

formation they often develop nonreflective professionalism. Additional exercises in or courses on professionalism as it is currently taught are, in themselves, unlikely to alter this dynamic, even if they are supplemented by lists of competencies that trainees are required to demonstrate. This rule-based approach to professionalism does not alter the tension or conflict between tacit and explicit values.

Instead, I propose promoting narrative-based professionalism as a more comprehensive approach to changing the culture of medical education and addressing its central paradox. This involves immersing students and young physicians in a wide array of narratives, drawn from their own experiences as well as those of others, that display professional virtue. In essence, this approach would provide a counterculture of virtuous practice that may gradually displace the more negative elements of contemporary medical culture and allow students to bear witness to their profession, not just symbolically through oaths and White Coat ceremonies, but in the ways they conduct themselves in their day-to-day practice. Each component of this approach—professionalism role-modeling, self-awareness, narrative competence, and community service—overlaps with and reinforces the others. Moreover, each lends itself to longitudinal evaluative processes, such as the creation of narrative-based professionalism portfolios by students and residents.<sup>32–36</sup>

Many of the elements for this development are already present, but in most medical schools dispersed too thinly and/or integrated too sparsely to produce a significant impact on the culture of medical education. I don’t know what critical mass might be required to initiate a chain reaction in medical education in favor of narrative-based professionalism. Presumably, however, it would not require that every faculty member and attending physician pass a litmus test for virtue and empathy. Nor would it mandate that commercialism disappear. The concept of a catalyst is important here because I believe that cultural change can take place if a relatively small number of well-placed faculty members, curricula, faculty development programs, and institutional supports are brought together with an aggressive treatment

plan not only to alleviate the symptoms of an ailing professional culture, but also to set that culture on the road to recovery.

## References

- 1 Mencken HL. The divine afflatus. In: A Mencken Chrestomathy. New York: Vintage Books, 1949 (reissued 1982).
- 2 Churchill LR. Reviving a distinctive medical ethic. *Hastings Cent Rep.* 1989;19:28–34.
- 3 Jonsen A. *The New Medicine and the Old Ethics*. Cambridge: Harvard University Press, 1990.
- 4 Beauchamp TL, Childress JR. *Principles of Biomedical Ethics*, 5th ed. New York: Oxford University Press, 2001.
- 5 Veatch RM. Against virtue: a deontological critique of virtue theory in medical ethics. In: Shelp EE (ed). *Virtue and Medicine: Explorations in the Character of Medicine* (Philosophy and Medicine series, No. 17). Dordrecht: D. Reidel Publishing, 1985:329–45.
- 6 Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics*. New York: Macmillan, 2002.
- 7 Pellegrino ED, Thomasma DC. *The Virtues in Medical Practice*. New York: Oxford University Press, 1993.
- 8 Pellegrino ED. Character, virtue and self-interest in the ethics of the professions. *J Contemp Health Law Policy.* 1989;5:53–73.
- 9 Pellegrino ED. The virtuous physician and the ethics of medicine. In: Shelp EE (ed). *Virtue and Medicine: Explorations in the Character of Medicine* (Philosophy and Medicine series, No. 17). Dordrecht: D. Reidel Publishing, 1985:243–55.
- 10 Drane JF. *Becoming a Good Doctor. The Place of Virtue and Character in Medical Ethics*. Kansas City: Sheed & Ward, 1988.
- 11 Coles R. *The Call of Stories: Teaching and the Moral Imagination*. Boston: Houghton Mifflin, 1989.
- 12 Accreditation Council for Graduate Medical Education. ACGME Outcomes Project (<http://www.acgme.org/Outcome/>). Accessed 7 July 2005.
- 13 American Association of Medical Colleges. Project Professionalism, Assessment (<http://www.aamc.org/members/gea/professionalism.pdf>). Accessed 7 July 2005.
- 14 American Board of Internal Medicine. Project Professionalism (<http://www.abim.org/pdf/profess.pdf>). Accessed 7 July 2005.
- 15 Barry D, Cyran E, Anderson RJ. Common issues in medical professionalism: room to grow. *Am J Med.* 2000;108:136–42.
- 16 Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA.* 2002;287:226–35.
- 17 Medical Professionalism Project. Medical professionalism in the new millennium: a physicians’ charter. *Lancet.* 2002;359:520–22.
- 18 American Board of Internal Medicine. *Professionalism in medicine: issues and*

- opportunities in the educational environment. *Project Professionalism*, p. 5 (<http://www.abim.org/pdf/profess.pdf>). Accessed 7 July 2005.
- 19 Bloom SW. The medical school as a social organization: the sources of resistance to change. *Med Educ*. 1989;23:228–41.
  - 20 Hafferty FW, Franks R. The hidden curriculum, ethics teaching, and the structure of medical education. *Acad Med*. 1994;69:861–71.
  - 21 Hunnert EM, Hafferty F, Christakis D. Characteristics of the informal curriculum and trainee's ethical choices. *Acad Med*. 1996;71:624–33.
  - 22 Stephenson A, Higgs R, Sugarman. Teaching professional development in medical schools. *Lancet*. 2001;357:867–70.
  - 23 Swick HM, Szenas P, Danoff D, Whitcomb ME. Teaching professionalism in undergraduate medical education. *JAMA*. 1999;282:830–32.
  - 24 Wear D, Castellani B. The development of professionalism: curriculum matters. *Acad Med*. 2000;75:602–11.
  - 25 Wear D. On white coats and professional development: the formal and hidden curricula. *Ann Intern Med* 1998;129:734–37.
  - 26 Coulehan J, Williams PC. Professional ethics and social activism: where have we been? Where are we going? In: Wear D, Bickel J (eds). *Educating Physicians: Medical Student Professional Development and Social Change*. Iowa City: University of Iowa Press, 2001:49–69.
  - 27 Coulehan J, Williams PC. Vanquishing virtue: the impact of medical education. *Acad Med*. 2001;76:598–605.
  - 28 Coulehan J, Williams PC. Conflicting professional values in medical education. *Camb Q Healthc Ethics*. 2003;12:7–20.
  - 29 Rothman DJ. Medical professionalism—focusing on the real issues. *N Engl J Med*. 2000;342:1284–86.
  - 30 Jonsen AR. Watching the doctor. *N Engl J Med*. 1983;308:1531–35.
  - 31 Inui TS. *A Flag in the Wind: Educating for Professionalism in Medicine*. Washington, DC: Association of American Medical Colleges, 2003.
  - 32 O'Sullivan PS, Reckase MD, McClain T, Savidge MA, Clardy JA. Demonstration of portfolios to assess competency of residents. *Adv Health Sci Educ Theory Pract*. 2004;9:309–23.
  - 33 Carraccio C, Englander R. Evaluating competence using a portfolio: a literature review and web-based application to the ACGME competencies. *Teach Learn Med*. 2004 Fall;16:381–87.
  - 34 Jarvis RM, O'Sullivan PS, McClain T, Clardy JA. Can one portfolio measure the six ACGME general competencies? *Acad Psychiatry*. 2004;28:190–96.
  - 35 Driessen E, van Tartwijk J, Vermunt JD, van der Vleuten CP. Use of portfolios in early undergraduate medical training. *Med Teach*. 2003 Jan;25:18–23.
  - 36 Challis M. AMEE Medical Education Guide No. 11 (revised): portfolio-based learning and assessment in medical education. *Med Teach*. 1999;21:370–86.
  - 37 Balint M. *The Doctor, His Patient, and the Illness*. New York: International Universities Press, 1972.
  - 38 Novack DH, Suchman AL, Clark W, Epstein RM, Najberg E, Kaplan MD. Calibrating the physician: personal awareness and effective patient care. Working Group on Promoting Physician Personal Awareness, American Academy on Physician and Patient. *JAMA*. 1997;278:502–9.
  - 39 Meier DE, Back AL, Morrison RS. The inner life of physicians and care of the seriously ill. *JAMA*. 2001;286:3007–14.
  - 40 Branch WT Jr., Pels RJ, Calkins D, et al. A new educational approach for supporting the professional development of third year medical students. *J Gen Intern Med*. 1995;10:691–94.
  - 41 Branch WT Jr, Kern D, Haidet P, et al. The patient-physician relationship: teaching the human dimensions of care in clinical settings. *JAMA*. 2001;286:1067–74.
  - 42 Pololi L, Frankel RM, Clay M, Jobe A. One year's experience with a program to facilitate personal and professional development in medical students using reflection groups. *Educ Health*. 2000;14:36–49.
  - 43 Suchman AL, Williamson PR, Litzelman DK, Frankel RM, Mossbarger DL, Inui TS. Relationship-Centered Care Initiative Discovery Team. Toward an informal curriculum that teaches professionalism. Transforming the social environment of a medical school. *J Gen Intern Med*. 2004;19(5 Pt 2):501–4.
  - 44 Charon R. Narrative medicine. A model for empathy, reflection, profession, and trust. *JAMA*. 2001;286:1897–902.
  - 45 Morris DB. Narrative, ethics, and thinking with stories. *Narrative*. 2001;9:55–77.
  - 46 Charon R. Narrative medicine: form, function, and ethics. *Ann Intern Med*. 2001;134:83–87.
  - 47 Frank AW. *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago: University of Chicago Press, 1995.
  - 48 Greenhalgh T, Hurwitz B (eds). *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice*. London: BMJ Books, 1998.
  - 49 Montgomery K. *Doctors' Stories: The Narrative Structure of Medical Knowledge*. Princeton: Princeton University Press, 1991.
  - 50 Morris DB. *Illness and Culture in the Postmodern Age*. Berkeley and Los Angeles: University of California Press, 1998.
  - 51 Bennett MJ. *The Empathic Healer: An Endangered Species?* New York: Academic Press, 2001.
  - 52 Coulehan J. An alternative view: listening to patients. *Lancet*. 1999;354:1467–68.
  - 53 Coulehan J. Tenderness and steadiness: Emotions in medical practice. *Lit Med*. 1996;14:222–36.
  - 54 More ES, Milligan MA (eds). *The Empathic Practitioner: Empathy, Gender, and Medicine*. New Brunswick: Rutgers University Press, 1994.
  - 55 Connelly J. Emotions, ethics, and decisions in primary care. *J Clin Ethics*. 1998;9:225–34.
  - 56 Bolton G. Stories at work: reflective writing for practitioners. *Lancet*. 1999;354:243–45.
  - 57 DasGupta S, Charon R. Personal illness narratives: using reflective writing to teach empathy. *Acad Med*. 2004;79:351–56.
  - 58 Charon R. Narrative and medicine. *N Engl J Med*. 2004;350:862–64.
  - 59 Williams CM, Wilson CC, Olsen CH. Dying, death, and medical education: student voices. *J Palliat Med*. 2005;8:372–81.
  - 60 Pitkala KH, Mantyranta T. Feelings related to first patient experiences in medical school. A qualitative study on students' personal portfolios. *Patient Educ Couns*. 2004;54:171–77.
  - 61 Coulehan J, Clary P. Healing the healer: poetry in palliative care. *J Palliat Care*. 2005;8:382–89.
  - 62 AMA Council on Ethical and Judicial Affairs. Code of Medical Ethics (<http://www.ama-assn.org/ama/pub/category/2512.html>). Accessed 7 July 2005.
  - 63 Elam CL, Sauer MJ, Stratton TD, Skelton J, Crocker D, Musick DW. Service learning in the medical curriculum: developing and evaluating an elective experience. *Teach Learn Med*. 2003;15:194–203.
  - 64 Haq C, Grosch M, Carufel-Wert D. Leadership Opportunities with Communities, the Medically Underserved, and Special Populations (LOCUS). *Acad Med*. 2002;77:740.
  - 65 Albritton TA, Wagner PJ. Linking cultural competency and community service: a partnership between students, faculty, and the community. *Acad Med*. 2002;77:738–39.
  - 66 Sidelinger DE, Meyer D, Blaschke GS, et al. Communities as teachers: learning to deliver culturally effective care in pediatrics. *Pediatrics*. 2005;115(4 suppl):1160–64.
  - 67 Clark DL, Melillo A, Wallace D, Pierrel S, Buck DS. A multidisciplinary, learner-centered, student-run clinic for the homeless. *Fam Med*. 2003;35:394–97.
  - 68 Davidson RA. Community-based education and problem solving: the Community Health Scholars Program at the University of Florida. *Teach Learn Med*. 2002;14:178–81.
  - 69 O'Toole TP, Kathuria N, Mishra M, Schukart D. Teaching professionalism within a community context: perspectives from a national demonstration project. *Acad Med*. 2005;80:339–43.
  - 70 Coulehan J, Williams PW, McCrary SV, Belling C. The best lack all conviction: biomedical ethics, professionalism, and social responsibility. *Camb Q Healthc Ethics*. 2003;12:21–38.