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# Learning Skills of Professionalism: a Student-Led Professionalism Curriculum

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***Abstract***

**Background:** Medical schools must address the fact that students embarking on careers in medicine are idealistic but have a vague understanding of the values and characteristics that define medical professionalism. Traditionally, we have relied primarily on unsystematic role modeling and lectures or seminars on related topics to teach professionalism.

**Methods:** A committee of students and a faculty advisor created a curriculum, based on a needs assessment of the targeted learners, to raise students' awareness of professional tenets and provide them with the skills to recognize and analyze conflicts between the values of professionalism and the daily pressures of medical school training. The student-run professionalism curriculum begins during medical school orientation and is followed by three student-facilitated case-based workshops over the next two years. All of the workshops involve small group discussions led by trained upperclass student facilitators. The workshops address the application of professional values to both the preclinical and clinical situations and prepare students for self-reflection, self-assessment and peer evaluation. We evaluated students' satisfaction following each workshop and pre/post attitudes for the first workshop.

**Results**: Twenty five upper-class student facilitators were trained in the first year. Student attendance ranged from 80-100% of the class (N=160), the proportion of students who agreed or strongly agreed that the workshops were educationally useful ranged from 60-75% for each workshop. Certain student attitudes improved immediately after the first workshop. These workshops continue annually.

**Conclusions**: Students have been a driving force behind this curriculum, which is a model for professionalism education. It was accepted by students and, although somewhat controversial, created a level of awareness and discussion regarding professional behavior in medical school that had previously been absent.

Many physicians will argue that professionalism has always been taught and modeled in medical training. Bedside teaching is cited as an example of the integrated lessons in professionalism offered to trainees.[1] Others have pointed out that, without explicitly addressing professionalism, it is not clear what students learn through passive observation. While students and residents might be noting admirable behaviors to include in their clinical repertoire, they may just as well be misinterpreting what they are observing or missing important points.[2] More explicit and structured approaches to promoting professionalism in medical students and residents need to be developed to assure this competency in all young physicians.

The term professionalism has suffered from lack of a precise operational definition and agreement on its behavioral manifestations.[3, 4] In our experience, faculty and peers are reluctant to identify and document individual trainees as unprofessional on the basis of relatively minor lapses in professional behavior. While this is compassionate, opportunities to modify behaviors are limited if one waits for high profile high risk lapses.[5] There is reason to believe peers are more accurate evaluators of professionalism. In particular, they may be the best measurers of interpersonal skills. Without precisely-defined components of professionalism, however, peer evaluation is fraught with difficulty.[6]

**Table 1: Goal and Objectives**

The goal of the Professionalism curriculum is to foster training-stage appropriate development of professionalism for medical students:

Specific Objectives:

- To enhance students' ability to recognize unprofessional behavior.
- To ensure students can analyze challenges to professionalism and negotiate a best course of action.
- To support students in accurately assessing themselves and their peer's professionalism.
- To provide students training in giving effective feedback.
- To create opportunity for peer leadership for professionalism curriculum.

Evidence supports that professionalism is best examined when students make context specific decisions in the face of conflict between and among the various professionalism tenets.[7] Therefore a physician's professionalism is not a stable set of traits, but a set of decision making skills applied in ambiguous situations. It follows that students must learn the professionalism tenets, understand the common scenarios in which professionalism is challenged, and be aware of options for behavior.[8]

In this paper, the founding students and faculty advisor of the professional development committee (PDC) describe the development, implementation and evaluation of the professional development curriculum offered to students by students at the New York University School of Medicine for the past five years. This curriculum emphasizes development of the skills of self- reflection, feedback to and communication with peers. In addition to a report of the curriculum, we will present some student evaluations of the Professional Development Curriculum, and our reflections on the curriculum, and its potential impact and drawbacks.

## Methods

**Curriculum development process -** The PDC, comprising student representatives from each class and a faculty advisor, was initially a part of the Liaison Committee for Medical Education (LCME) self-study process. A targeted needs assessment of students in the entering class of 2006 during orientation to medical school was conducted. From responses to a questionnaire (96% response rate), we learned 77% of students consider themselves professionals on graduation from college or by the time they enter medical school, while some ( 2%) still will not until they graduate from residency.

An analysis of students' answers to the question "What values, attitudes, or behaviors are necessary for professionalism in physicians?" revealed that most students emphasized interpersonal qualities such as honesty, respect, compassion and altruism. Fewer students commented on a commitment to communities or social justice, accountability to society, excellence or a need to participate in self and peer-regulation. We set out to first develop a curriculum that would raise awareness of professional tenets and provide students with the skills to recognize, analyze, reflect on, and give feedback about conflicts between values of professionalism and daily pressures of medical school training.

There are several underlying assumptions and principles of our professional development curriculum. First, students begin their professional lives with the start of medical school. Second, teaching professionalism involves both respecting the knowledge and values with which medical students enter school and offering opportunities to practice their application in challenging situations. Third, self-reflection and active discussion among peers are fundamental to the professional growth of all physicians throughout their careers. Fourth, student involvement in both the development and implementation of such a program is crucial to its acceptability.

**Curriculum structure** - Our curriculum begins during medical school orientation and continues as three interactive case-based workshops that provide an opportunity for students to discuss real-life scenarios with their peers. All cases are developed by students based on actual experiences. During orientation week, on the same day as the white coat ceremony, students are given a brief introduction to the definition of professionalism and the PDC.

Each of the workshops follows the same basic format. Goals for the session are outlined in a large group setting; students then break out into case discussion groups of 8-10 students, led by a trained upper-class student facilitator and, when possible, co-led by a house officer. The small group concludes each case discussion

by arriving at a consensus opinion. Following this the students reunite in the larger group and debrief all of the cases that were discussed.

**Self assessment workshop (first half of the first year) -** Using cases relevant to the pre-clinical years we introduce the idea that students exhibit their professionalism in the everyday choices they make, and we encourage the process of self-reflection. Table 2 gives an example of a case. Others include creating a disturbance by leaving lectures early and unconstructive e-mail correspondence with faculty following an exam.

**Peer assessment workshop (second half of the first year) -** The second workshop is designed to help students develop the language and skills to exchange effective feedback with their peers. A trigger videotape is shown that exaggerates common unprofessional behaviors among students in a small group case conference. Role play is used in small groups to demonstrate and practice formulating feedback and discuss the importance of focusing on modifiable behaviors.

**Table 2: Case Studies in Pre-Clinical Professionalism with Facilitator Notes**

**The Case:**

Throughout college, Joshua did well in classes by cramming for four days before finals. Even during his first semester of medical school, this study strategy is working well enough for him to maintain passing grades. He thinks that preparing for a basic science small group case based discussion is a waste of time since he usually forgets all of the minutiae discussed there by the week of the test anyway. Still, he shows up at conference, since it is "mandatory", but he has his head down through parts of it, and usually tries to dodge being called on, or jokes his way out of having to provide an answer when it is his turn to speak.

**Facilitator Discussion Guide:**

a. What is Joshua's motivation for not preparing for conference?

- Time management
- Making a point that the conference is useless

b. What are the responsibilities of each group member? What about very shy students; are they meeting their responsibilities if they are well prepared, but not vocal in a group setting?

- Helping others learn the material (Altruism)
- Practice small group communication, presenting and active listening
- Learn to communicate in scientific language
- Professional development –Group interaction is the major mode of decision-making in patient care.
- You are responsible for your learning.
- Be honest/ upfront about your own level of preparation

c. Does Joshua have a right to approach conference this way? (Excellence, Duty, Accountability, Respect)

- Risks detracting from the group learning, slow the pace, are disesteemed in the eyes of the facilitator and peers
- Misses out on development of communication skills, verbalization/ explanation of his ideas, peer interaction, public speaking, small setting faculty interaction, and participating in the group dynamic.

d. Is it okay to be unprepared? Is it realistic to expect students always to be well-prepared?

e. Principles of professionalism:

- Excellence
- Accountability
- Respect for the group
- Honesty
- Integrity

***BE SURE TO COVER:

The importance of functioning constructively in a group during graduate school, residency, and as attending physicians. Discuss the group evaluations for the spring and remind them to keep an eye out for the dynamic in their own conference groups.

**What should the expectations be regarding this behavior...?**

**Clerkship orientation workshop (second half of the second year) -** The final workshop aims to introduce students to the difficult situations they will face in their new role on the wards as they interact with patients, housestaff, attendings, and support staff. The cases include the disclosure of information to patients, performing procedures for the first time, dealing with difficult patients and chemically impaired house officers. An example is shown in Table 3.

**Facilitator training -** Student facilitators are prepared in training sessions prior to each workshop. In

**Table 3: Case Studies in Clinical Professionalism with facilitator notes**

**The Case**:
During her medicine rotation Tanya's resident asks her to interview and do a complete physical exam on a newly admitted patient. The patient is a 50 year old man who complains of shortness of breath. He is unkempt, has open sores on his arms, and there is the smell of alcohol in his room. When he reaches out to shake her hand Tanya recoils and finds herself feeling nauseated. During the interview, she learns that he is an I.V. drug user, HIV positive, and homeless. He has been admitted many times in the past year and often comes to the Emergency Room. After the interview Tanya puts on gloves and does an abbreviated physical exam. She winces as she comes close to him to listen with her stethoscope and tries to maintain her distance as much as she can through the rest of the exam. She decides to skip the neurological and musculoskeletal exams completely in order to avoid touching his arms. When she is finished she barely says good-bye and heads straight for a bathroom to wash her hands and calm down.

Facilitator Discussion Guide

1. What do you think? Is this realistic?
2. What is the conflict in this case?
   - expression versus control of emotion
   - patient care versus personal comfort
   - assumptions versus open mind
   - sanitation versus offensive behavior
3. What are some options for the student?
   - Apologize and do a thorough exam (Is it necessary to apologize? Does the patient deserve it?)
   - Don't apologize and do a thorough exam
   - Seek advice, reflect on response to patient
   - Seek help—to focus her on the exam
   - Pass the patient on to someone else, ask them to do the parts of the exam she missed
   - What language will be used on the chart? "normal," "could not obtain"
   - Leave it as is
4. Modifiers
   - What if the patient is malingering?
   - What if he is known to be habitually non-compliant?
   - What if the patient is insulting, emotionally abusive?
   - What if the patient is unaware? Ex/ comes into ER in a coma…is it ok to make comments to others at the time?
   - What if she is confident that the missed exams aren't pertinent to the problem?
5. As a representative of the medical profession, when is talking about your "disgusting" experiences ok?
   - What about talking to medical school friends? Asking them for advice...
   - What about telling "horror stories" to friends outside of school?
6. More notes on the case:
   - Tricks of the trade?
   - Understand your own reactions or triggers (e.g. disgusting smells, sight of blood) and prepare if you can.

You don't know exactly what your trigger is, everyone has one although this situation may not be it—can only prepare non-specifically

**Table 4: Self-Assessment Attitudes Survey: Administered immediately pre and post the workshop.***

| Attitude Statements | Pre-workshop Mean (S.D) | Post-workshop Mean (S.D) |
|---|---|---|
| Medical students should be expected to behave professionally. | 4.65 (.669) | 4.68(.596) |
| I understand the definition of professionalism. | 4.07(.684) | 4.12(.728) |
| My behavior in school is social and shouldn't be evaluated. | 2.71(.967) | 2.43(.922)† |
| I feel included in the development of a professionalism assessment program. | 2.91(1.092) | 3.32(.931)† |
| There is a need for higher standards of professionalism in medical school. | 3.18(.844) | 3.54(.802)† |
| Professionalism is *not* a relevant topic for students in preclinical years. | 1.98(.953) | 1.77(.916)† |
| I already receive feedback on my professional behavior. | 2.47(.989) | 2.59(1.001)† |
| I feel I can recognize professional and unprofessional behavior in my teachers. | 4.14(.707) | 4.11(.670) |

*(1 = strongly disagree, 5 = strongly agree). N=111/160 (69%) class of 2009 (Cronbach's Alpha =.59)
†The difference between Pre and Post Workshop mean is statistically significant at a level of P<.05

this training session students express their own opinions about the case, and the training leader highlights the professionalism values as they come up naturally in discussion. With this as a starting point, we discuss the basics of facilitating a discussion group and highlight the need to remain neutral and non-judgmental, to create a safe speaking environment, and to listen and prompt discussion. Students are invited to discuss their concerns, which typically include the participant who does not think professionalism can or should be taught, who monopolizes the conversation or who does not speak at all. Each facilitator is given a discussion guide that includes questions to prompt discussion, alternate scenarios, and the general principles each case raises. Armed with these notes, the training session, and their own experiences with the workshops, students are prepared to lead the case discussions.

**Evaluation -** The Professional Development Curriculum was evaluated in several ways. We tracked attendance rates in the first year of the curriculum. Following each workshop, we asked students to assess whether they found the workshop to be worthwhile using a four-point strength of agreement scale. We also obtained data from the Dean's Office student evaluation survey that assessed four specific aspects of the Clerkship Orientation workshop on a strength-of agreement-scale of one to five, where five was strongly agreed. Immediately before and after the Self Assessment workshop for the class of 2009, we assessed eight attitudes which we felt measured receptivity to learning about professionalism based on the formal needs assessment and our experience. All data were collected anonymously. Attitude data was paired and therefore could be analyzed statistically using paired t-tests.

## Results

**Implementation and Attendance -** Students were encouraged but not required to attend the professionalism sessions sponsored by the Dean's Office and the PDC. Attendance at each of the sessions ranged from 80-100% of the class (N=160/class). Twenty-five upper class student facilitators were trained in the first year of the program, and there has been no difficulty recruiting the needed number of students in subsequent years. Each year housestaff from Internal Medicine, Pediatrics, Psychiatry, Emergency Medicine and Surgery have participated as co-facilitators for the clerkship orientation workshop.

**Student Satisfaction -** In the first year of the professionalism curriculum, 60% of students (79/131) agreed or strongly agreed that the Self-Assessment Workshop was worthwhile, and 74% (70/94) agreed or strongly agreed that the Peer Assessment Workshop was worthwhile. After the Clerkship Orientation Workshop 73% (116/160) of students completed a more specific Dean's Office Student Evaluation Survey and reported that the workshop reinforced expectations of professional behavior (mean 3.3, scale 1-5) and personal responsibility (mean 3.5, scale 1-5), clarified the implication of professionalism (mean 3.3, scale 1-5), and the small group format allowed for honest discussion of the issues (mean 3.8, scale 1-5).

**Student's attitudes toward professionalism curriculum -** Table 4 shows the mean responses of students regarding attitudes relevant to medical professionalism curriculum and assessment immediately before and after the self-assessment workshop. Pre- and post- surveys were completed by 69% (111/160) of students in the class of 2009. The internal reliability of the eight items

was moderate (Cronbach's alpha= 0.59) suggesting that it would be more meaningful to report individual item scores only.

**Discussion**

We have created, implemented, and sustained a student-generated and student-led professional development curriculum for preclinical students. While most of the entering students at NYUSOM understand the personal qualities and interpersonal behaviors expected of physicians (i.e. honesty, compassion, integrity, respect), they do not fully understand how these values apply in practice. Most students are largely unaware of the privilege and responsibility given to the profession by society to self-regulate.[9] We have addressed some of these issues by engaging students in an ongoing discussion using common examples relevant to their own stage of training. This series of professional development workshops is well attended and generally acceptable to students (the typical course evaluation at NYU receives mean 3-4 on a 5 point scale). Students felt the workshop series to be a good use of time, and that they raised their awareness of professionalism values and how these values are transmitted and expressed. In addition, this work has energized the student leadership and has created a cadre of trained student facilitators who can function as student role models.

The high attendance rate at our voluntary events is evidence of the engagement of most students in this curriculum. The self assessment workshop, the first of the series, had a generally positive impact on student attitudes immediately post-workshop. Given the incomplete response rate, we cannot be certain how to generalize from these immediate changes in attitudes, but we are encouraged by them because the issues raised in the workshop are complex and personally challenging for students. As Hafferty and others have observed, formally raising issues of professionalism may cause a "values conundrum" for students.[10] We speculate that our cases make some students newly aware that unprofessional behaviors are common among preclinical students (e.g. disrespect to faculty and peers, cheating and not keeping commitments). The subject matter makes some students defensive, which we acknowledge and attempt to address by designing the small group discussions to ensure that students feel free and safe to voice negative and unacceptable views without being judged. This preliminary data has informed a study, currently underway, of the longer term impact of our curriculum on a larger range of attitudes.

**Lessons Learned -** Our experience with this approach to professionalism education taught us a number of lessons: a small group discussion format is far superior to large group experiences in addressing professionalism material, peer feedback is a skill that can be learned, and peer education is a very effective instructional strategy. Most educators would support that active case-based discussion is crucial for a long lasting impact on student attitudes and values. This is because it exposes students to the beliefs of others and challenges them to articulate their own ideas.[11,12] Students discover the diversity of student and faculty opinion on this topic,[13] and they realize that their colleagues may possess different priorities, assumptions and ideas about how the tenets of professionalism are applied. We ask students to come to a consensus as an explicit example of how the process of self-regulation can be exercised respectfully and openly. We believe that having students discuss situations before they encounter them better equips them to make the best choices, especially when faced with conflicting values. We also are modeling a culture in which peers will feel free to seek counsel from each other.

While the idea of peer feedback is often met with resistance in medical school, if done respectfully, it is a valuable learning tool and an essential skill of a professional.[14] Since evaluation among peers is occurring informally anyway, we feel that it is important to arm students with the skills to formulate effective feedback and to create opportunities to share their thoughts. In this way, students learn more about themselves and their skills. In addition, they may be immunized against the intense pressure "not to reflect 'too much' on what is happening around them" that many see as a hidden but potent message in medical training environments.[10] As we have seen, and has been noted at other institutions, students are willing to participate in peer assessment if given support and guidelines.[14]

Students have been a driving force behind this curriculum. In fact, student leadership and facilitation, a concept not common in the traditional hierarchy of medical training, has been fundamental to the success of our program. Given the highly subjective nature of professionalism, we have found that this "bottom up" approach of student involvement is essential to the creation of an accepted and realistic professional development curriculum. It empowers students to direct their own learning agenda and creates an environment of student-to-student mentoring as opposed to didactic instruction. In addition, this approach has the added advantage of providing leadership experience and facilitation skills to a substantial number of upper classmates, thereby creating a resource to expand the impact of this curriculum to others.

While this is a report of one school's experience in developing a professionalism curriculum and may, therefore, have limited generalizability, we hope we have provided sufficient detail to allow students elsewhere to create their own locally appropriate program. Not having a true experimental control group limits our ability to fully delineate the educational effectiveness and impact of our curriculum. However, we believe our program provides a model to address this area of competence which is currently of great interest to medical educators internationally.[15]

**Conclusion**

The erosion of professionalism during medical training has been documented.[16] Still the unrealistic belief that with minimal guidance medical students will "do the right thing" persists. We believe that students' professional development requires more structured support and benefits from the creation of a culture in which feedback is frequently and skillfully given. Our medical student led professional development curriculum uses a skills-based and self-reflection-centered approach to encourage students to nurture their own understanding of professionalism and to recognize how their behavior, even early in the course of medical training, constitutes an expression of their professionalism. In this way, we prepare to enter a rapidly changing health care system and contribute as full-fledged physicians.

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