Leadership for Reaffirmation of Professionalism

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Throughout the academy, whenever the topic of professionalism is raised at faculty meetings and retreats, lively and at times impassioned discussion ensues. We quickly focus on presumed student deficiencies in the attitudinal and behavioral realm that compromise learning and do not serve the needs of the patient or the treatment team. Unfortunately, we seldom adequately evaluate our possible roles in development of these behaviors and what strategies could be taken to remedy them. This is not to imply that the faculty or administration have the sole or even the major responsibility for manifestation of these behaviors. The purpose of this brief article is to encourage broad based discussion and careful evaluation within our schools and colleges to define the issues relating to professionalism and to develop practical strategies to foster professionalism in students and faculty.

Students and faculty at times define unprofessional behavior as anything that they do not like. There is merit in students and faculty in each of our colleges establishing a definition of a profession and of professionalism. Various authors have defined professions differently. Some definitions acknowledge that a profession requires education and training that is intellectual, involving knowledge and not just skills. Commonly, professions are described as work pursued for the primary benefit of others and not for oneself. Definitions may point out that success in professions is measured by more than financial return(1). Commonly, self-regulation and autonomy are held up as critical components of professions(2,3). Medical professionalism has been defined as a set of values, attitudes, and behaviors that result in serving the interests of patients and society before one's own interests(4). Professional values are proposed to include honesty, integrity, humility, and accountability to patients, colleagues, and society. Professional behaviors in the health care setting are postulated to include the stresses of training experiences and a lack of confidentiality? Do we always show appropriate respect for patients' feelings and not serve the needs of the patient or the treatment team.

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Barriers to the Development of Professionalism

Within the medical education model (including residencies), impediments to the development of professionalism have been postulated to include the stresses of training experiences and a lack of effective mentoring and role modeling(6,7). Reynolds(8) considers the education community and its role in transmitting professional values and behaviors. He identifies factors that undermine professionalism in the academic/training environment, and argues for strategies to reaffirm medical professionalism among physicians-in-training and faculty. I believe there are important parallels in education and residency training between pharmacy and medicine, and we would do well to undertake a careful assessment of the barriers to development of professionalism in our own camp. There may be important lessons to be learned from looking at the medical literature.

We need to consider the role of our education communities in the professionalization of pharmacy students and residents. I submit that the learning of values and behaviors best occurs in a learning community with explicit expectations, and that effective role models are essential to the process.

Over specialization in medicine is proposed to constitute a barrier to development of professionalism in medical education. It is suggested to contribute to a diminished sense of a shared value system and a weakening of the relationships among the faculty, house staff, and medical students(8). Also, it is suggested that feelings of collegiality across the medical teaching faculty have been replaced by self-interest, intense competition for control of limited resources, and loyalties to the goals and values of the specialty division or research team(9). Further, specialty oriented faculty may have shifted the focus of their teaching from medical students to fellows.

Are there parallels to pharmacy education here? Few would seriously argue the practice of pharmacy is overspecialized. However, we have seen an evolution within the academy whereby faculty loyalties are often shifted to departments or to the research group within departments. Our faculty are of necessity becoming more competitive for control of limited resources, and in some cases, the emphasis of faculty teaching has been shifted to graduate students or to residents and away from pharmacy students. Does this weaken the relationships between faculty and students and create a barrier to the development of professionalism? Does the positioning of fellows, graduate students, and residents between faculty and students jeopardize role modeling and mentoring of students that is essential to the development of professionalism?

In medical education, a faculty reward system that favors publication and presentation more than teaching has also been identified as undermining the education community(10). Clearly, pharmacy faculty are also under pressure to write more grants, conduct more research, and publish and present more papers. Does our frequent absence from the educational environment undermine the education community that fosters the development of professionalism? Many pharmacy faculty, although consummate professionals, have never practiced or even trained in a professional pharmacy setting. Is it more difficult for students to recognize and emulate professional behaviors and attitudes of these faculty?

Some in medical training have postulated that there is now a lower standard of professional conduct in the clinical setting than was common a few years ago. Patients are evaluated in a more cursory way, they are discharged sooner, and less of a relationship is established between the patient and the physician or resident(6,7). Medical students report hearing residents and faculty refer to patients in derogatory terms, and the desires of patients are at times unheeded(5). Are there examples of similar behaviors in pharmacy? Do we always model appropriate respect for patients' feelings and confidentiality? Do we always show appropriate respect for the opinions and ideas of our pharmacy colleagues, or do we at times air our personal feelings and dirty laundry in the presence of students? Do these behaviors lower the standard and give graduate students, pharmacy students, and residents "permission" to behave similarly?

Reynolds(5) posits that when one's profession becomes simply a career rather than a calling, then the standards become more impersonal, i.e., there is an orientation to attaining success rather than assuming a function within a community with responsibilities to that community. Are more pharmacy faculty shifting their focus away from service and responsibility to the larger community and toward the attainment of success? Does our reward system lower our standards by minimizing our profession as a calling?

Although lessons can likely be learned from the experiences of
medical education, it is important to recognize that pharmacy is not medicine, and we must also explore how factors unique to pharmacy may impact the development of professionalism. Most pharmacy graduates do not undertake a residency, and most who do, have only one year of residency. Therefore, there is less time for teaching, role modeling, and mentoring our students and residents. Some of our preceptors may not fully accept or endorse all the precepts or vision of professionalism taught or personified by regular, full time faculty.

**Strategies for Reaffirming Professionalism**

And what if all of this is true? What can we do about it? The very nature of our educational and training systems requires that we contribute to graduate, residency, and fellow education and training. The success of our individual programs, faculty promotions, and our institutions’ national recognition depend upon our success in the research arena and the dissemination of our findings. This is our world, it is real, and it isn't likely to change in the near future. Further, there is no consensus among faculty that it should change. Reynolds, (5) in the example of medical education, suggests four strategies. The first is to create an education community focused on a core teaching faculty, continuity of care within a patient population, and structured learning time. In the clinical pharmacy education setting, faculty, residents, students and other health professionals can be grouped into treatment teams that set aside time for instruction and to whatever extent possible, provide care to a stable population of patients longitudinally in the inpatient and outpatient settings. Outside the clinical setting a core of teaching faculty and graduate students involved in teaching (under the supervision of faculty) could work with small groups of students over a period of time adequate to allow that a relationship be established between instructors and students.

Secondly, Reynolds(5) encourages developing programs for role modeling and mentoring and rewarding activities among the faculty members who support these programs. At our pharmacy colleges, this may require establishing a cadre of teaching faculty and an appropriate reward system to encourage a focus on teaching excellence. This concept may be unfamiliar to some pharmacy programs at present. Role models serve as an ideal to which the student can aspire. A mentor establishes a relationship with the student which helps the student learn attitudes and skills difficult to assimilate. Mentoring is effective only if there is a "connection" between the mentor and student, and establishing and maintaining this “connection” is time consuming. It is critical that these activities are recognized and rewarded by administrators in pharmacy education. Unless role models earn the respect (not necessarily the friendship) of students, students will not assimilate the values and behaviors of their role models, no matter how laudable.

Thirdly Reynolds(5) recommends implementing a curriculum on medical professionalism, including seminars, community service activities, and an academic commitment to teaching professionalism. The topics in such a pharmacy curriculum could be drawn from the daily lives of practicing pharmacists and those in training. The curriculum should provide opportunities for self-reflection by students, and it could provide readings and group discussions. In the Reynolds model, core topics could include putting the patient first; integrity; appropriate use of authority; responsibilities to the patient, the community, and to colleagues; and the importance of life-long learning.

Lastly, Reynolds(5) recommends evaluating physicians-in-training and faculty on their professional conduct. In the world of pharmacy education, this assessment could be incorporated into our annual faculty reviews, post-tenure reviews, course and instructor evaluations, and evaluations of students in group activities and in practice experiences.

I want to recommend that pharmacy faculty and administrators read about Project Professionalism, sponsored by the American Board of Internal Medicine (ABIM). It is described in some detail on the ABIM web site (http://www.abim.org/pubs/default.htm). This was a multi- year project designed to define professionalism, raise the concept of professionalism in the consciousness of all within internal medicine, assist residency program directors in fostering professionalism, and develop strategies for assessing professionalism in residents and fellows. This report defines terms, makes recommendations, identifies barriers, and also offers professionalism vignettes. There is much in this report to raise our awareness, inform our thinking, and assist us in initiating the discussions that must take place within pharmacy education.

Professionalism is fundamental to the profession of pharmacy. Indeed, it is difficult to imagine a proficient pharmacist practitioner, no matter how knowledgeable and skilled, who does not embody and exhibit professional behaviors and attitudes. I believe the time is at hand when we can no longer blindly trust that professionalism will magically be developed in our students. We must intentionally craft a curriculum that facilitates the development of professional behaviors, design didactic and experiential environments that support such development, and carefully assesses our success in meeting the goals of the curriculum for fostering professionalism. I encourage faculty and administrators to design strategies for working together to ensure that professionalism is reaffirmed in the academy.

**References**

(1) Brandeis, L.D., Business—A Profession, Hole, Cushman, and Flint, Boston MA (1933) p 75.