



MEDICAL
PROFESSIONALISM
PROJECT

ABIM Foundation
ACP-ASIM Foundation
European Federation of Internal Medicine

Professionalism: Current Approaches

**American Academy of
Neurology, Ethics,
Law, and Humanities
Committee.
Humanistic
dimensions of
professionalism in the
practice of neurology.
Neurology.
2001; 56:1261-3.**

In order to encourage neurologists to resolve time pressures in their patients' favor, and to help dispel the false and destructive notion that humanistic practices are now expendable inefficiencies, the American Academy of Neurology, Ethics, Law and Humanities Committee summarizes humanistic professional attributes considered intrinsic to good neurologic practice.

American Board of Internal Medicine. Project Professionalism. American Board of Internal Medicine. Philadelphia. 1995.

In the last few decades, advances in medical knowledge and technology have placed greater pressures on physicians to absorb and communicate information to patients and other health professionals. In the wake of these changes, unprofessional behavior and attitudes have eroded medicine's respected position. This document emphasizes the signs and symptoms that erode professionalism, describes aids to professionalism, and presents vignettes which illustrate the unique nature of these quandaries.

American College of Physicians. Ethics manual, fourth edition. Ann Intern Med. 1998; 128:576-594.

Some aspects of medicine are fundamental and timeless, but medical practice does not stand still. Clinicians must be prepared to deal with changes and reaffirm what is fundamental. This manual examines emerging issues in medical ethics and revisits older issues that are still very pertinent. The publication is intended to facilitate the process of making ethical decisions in clinical practice and medical research and to describe and explain underlying principles of decision making.

Arnold EL, Blank LL, Race KEH, Cipparrone N. Can professionalism be measured? The development of a scale for use in the medical environment. Acad Med. 1998; 73:1119-21.

This article assesses a scale that measures professional attitudes and behaviors associated with the medical education and the residency training environment. Drawing on a survey of more than five hundred medical students and residents, the authors find encouragement toward the development of a reliable measurement scale.

Barry D, Cyran E, Anderson RJ. Common issues in medical professionalism: room to grow. Am J Med. 2000;108:136-42.

This study assesses responses to common challenges to medical professionalism and to ascertain physician satisfaction with training in professionalism. The authors used a series of vignettes which highlight important challenges to medical professionalism. They found that physicians were more likely than house officers to provide the most acceptable response, and house officers in turn were more likely than medical students. The most difficult scenario involved physician impairment, where only 12% of respondents gave the best answer. Other important findings involve the scope of formal training in professionalism provided to physicians, and the extent of satisfaction with such training.

Berger AS.
Arrogance among physicians.
Acad Med.
2002;77:145-7.

Arrogance among physicians is, regrettably, common and violates the benevolent spirit of medicine – its very soul – as well as the quality of medical care. The need for humility in the physician warrants greater emphasis in medical training, both in the classroom and, more critically, by example. Arrogance persists because of intersecting and mutually enhancing sociologic and psychologic pressures.

Berwick D, Davidoff F, Hiatt H, Smith R.
Refining and implementing the Tavistock principles for everybody in health care.
British Med J.
2001;323:616-20.

The Tavistock Group has worked to develop ethical principles that might be useful to everybody involved in health care. They were intended for those who are responsible for the healthcare system, those who work in it, and those who use it. This article describes the origins of the principles, discusses the thinking behind them, considers how they might be used, provides case studies, and reflects on where the venture might go now.

Bossers A et al.
Defining and developing professionalism.
Can J Occup Ther.
1999; 66:116-21.

A group of faculty, clinicians, and students at Elborn College was charged to examine professionalism and to make recommendations for curriculum planning and development. A schematic representation of professionalism was developed through a review of the literature and qualitative analysis of information obtained from discussion groups. This paper presents that representation and information about two supported self-study courses. A professional portfolio guide for the student occupational therapist is also described.

Brennan TA.
Luxury primary care - market innovation or threat to access?
N Engl J Med.
2002; 346:1165-8.

Primary care practitioners in several states have recently decided to restructure their practices in a way that enables them to see a much smaller number of patients and to spend more time with the ones they do see. Some physicians have criticized this approach, pointing out that only the wealthy can afford such amenities. They also claim that these practices are unethical. The author examines the features of luxury primary care practices and discusses the legal and ethical issues that arise with such practices.

Brownell AKW, Cote L.
Senior residents' views on the meaning of professionalism and how they learn about it.

Acad Med.
2001; 76:734-7.

This study demonstrates that residents' knowledge about professionalism reflects their early stage of development as physicians and their daily activities, where such aspects of professionalism as the social contract, codes of ethics, participation in professional societies, and altruism are not highlighted.

Burns LR, Cacciamani J, Clement J, Aquino W.
The fall of the house of AHERF: the allegheny bankruptcy.
Health Aff.
2000; 19:7-41.

The \$1.3 billion bankruptcy of the Allegheny Health, Education, and Research Foundation (AHERF) in July 1998 was the United States' largest nonprofit health care failure. Many actors and factors were responsible for AHERF's demise. The system embarked on an ambitious strategy of horizontal and vertical integration just as reimbursement from major payers dramatically contracted, leaving AHERF overly exposed. Hospital and physician acquisitions increased the system's debt and competed for capital, which sapped the stronger institutions and led to massive internal cash transfers. Management failed to exercise due diligence in many of these acquisitions. Several external oversight mechanisms, ranging from AHERF's board to its accountants and auditors to the bond market, also failed to protect these community assets.

Burrow GN.
The liberal arts physician. *Acad Med.*
1999; 74:1063-6.

The author calls on academic medical centers to restore elements of the liberal arts – including integrated teaching, adaptability, and value-based decision making – to the modern medical curriculum.

Chambers DW.
Professional development.
J Am Coll Dent.
1999; 66:43-7.

The author maintains that the current program of continuing education is unnecessarily restricted by outdated conceptions of professionalism and learning; thus it fails to serve the needs of dentists today. A new model – professional development – is proposed, based on new ideas about what it means to be a professional and what professionals learn. The central role of practice is emphasized.

**Chervenak FA,
McCullough LB.
Professionalism and
justice: ethical
management
guidelines for leaders
of academic medical
centers.
Acad Med.
2002; 77:45-7.**

The ethical concepts of professionalism and justice can be used to create a vital, practical, alternative vision for the leadership of AHCs, in which their missions once again become central to their organizational culture. Creating a morally sustainable organizational culture of professionalism and justice should rely not on forced cooperation, but on voluntary cooperation of all stakeholders in the pursuit of a common goal – professional excellence in patient care, teaching, and research – with survival understood to be a means to this goal.

**Cohen JJ.
Measuring
professionalism:
listening to our
students.
Acad Med.
1999; 74:1010.**

This concise statement by the President of the Association of American Medical Colleges calls on medical educators to pay as much attention to the evaluation of professionalism in medical students as they do to the evaluation of clinical expertise. The author proposes the introduction of peer review as a useful method for promoting the measurement of professionalism in academic medical environments.

**Cruess RL, Cruess
SR, Johnston SE.
Renewing
professionalism: an
opportunity for
medicine.
Acad Med.
1999; 74:878-84.**

In recent decades, both the concept and the performance of professionals have been widely questioned. Professionalism and the idea of service have been placed under intense pressure, but they have survived. Medicine may now have an opportunity to reestablish itself as a respected, influential, and useful profession in Western society. To take advantage of this opportunity, the authors offer several recommendations addressing the doctor-patient relationship, education about professionalism, and the role of local and national associations.

**Davidoff F.
Changing the subject:
ethical principles for
everyone in health
care.
Intern Med.
2000; 133:386-9.**

Over a year ago the *Annals of Internal Medicine* and the *British Journal of Medicine* published a working draft of ethical principles for everyone in health care. This brief editorial reviews the seven primary principles elucidated by that working group, including Rights, Balance, Comprehensiveness, Cooperation, Improvement, Safety, and Openness, and presents numerous insights gleaned from recent discussions of these principles.

DeLisa JA, Foye PM, Jain SS, Kirshblum S, Christodoulou C.
Measuring professionalism in a psychiatry residency training program.
Am J Phy Med Rehabil. 2001;80:225-9.

A twelve item questionnaire modeled after the one prepared by the ABIM dealing with professionalism was distributed to 122 psychiatry residents representing six training programs, of whom 59% responded.

Epstein RM, Hundert EM.
Defining and assessing professional competence.
JAMA. 2002; 287:226-35.

Current assessment formats for physicians and trainees reliably test core knowledge and basic skills. However, they may underemphasize some important domains of professional medical practice, including interpersonal skills, lifelong learning, professionalism, and integration of core knowledge into clinical practice. This article proposes a definition of professional competence, reviews current means for assessing it, and suggests new approaches to assessment.

Epstein RM.
Mindful practice.
JAMA. 1999; 282:833-9.

The author discusses the elements of mindful practice, wherein practitioners attend in a nonjudgmental way to their own physical and mental processes during ordinary, everyday tasks. This critical self-reflection enables physicians to listen attentively to patients' distress, recognize their own errors, refine their technical skills, make evidence-based decisions, and clarify their values so that they can act with compassion, technical competence, presence and insight.

Finkel MA, Adams JG.
Professionalism in emergency medicine.
Emerg Med Clin North Am. 1999; 17:443-50.

At its root, medical professionalism is service delivered according to patient's interest. It is essential to reinforce this notion because financial pressures threaten the integrity of the patient-physician relationship. Excessive commercialism directly contrasts the ideals of medical professionalism. This fact necessitates reexamination and reaffirmation of professional behavior. Medicine can never succeed as a transaction; it can only succeed as a partnership, a trusting exchange with patients, which is the hallmark of professionalism.

**Frankford DM,
Konrad TR.
Responsive medical
professionalism:
integrating education,
practice, and
community in a
market-driven era.
Acad Med. 1998;
73:138-45.**

Revolutionary changes in the nature and form of medical practice institutions are likely to reverberate backward into medical education as leaders of the new practice organizations demand that the educational mission be responsive to their needs, and as these demands are increasingly backed by market power. In the face of this pressure, medical education's traditional response – that is should have autonomy in defining its mission – is no longer viable. Instead, more explicit, formal, and systemic linkages between practice and educational institutions are inevitable. The crucial question is whether these linkages will reflect the values of the market, oriented by economic self-interest, or the values of medical professionalism, oriented by the obligation to sacrifice economic self-interest in the service of patients.

**Gillon R et al.
Wanted: a social
contract for the
practice of medicine.
*British Medical
Journal.*
2001; 323:64.**

In this concise editorial, the authors propose that an independent high level standing commission be created to determine socially acceptable norms and draw up and maintain a "social contract" between healthcare workers and the community they serve.

**Ginsburg S et al.
Context, conflict, and
resolution: a new
conceptual
framework for
evaluating
professionalism.
Acad Med.
2000; 75:S6-11.**

While the need to evaluate professionalism effectively has been recognized for some time, the authors argue that traditional methods of addressing the problem have not been successful. These standard methods rely on abstract and idealized definitions which place the focus on people, rather than their behaviors, and imply that professionalism is simply a stable set of traits. The authors posit that, contrary to this prevailing conception, evaluation of professionalism is incomplete. They identify several important components which are missing from the current framework, including consideration of the context of unprofessional behavior, the conflicts which lead to lapses, and the reasons behind students' decisions.

Hafferty FW.
Managed medical education?
Acad Med.
1999; 74:972-9.

The author reflects that because corporate managed care is already established in teaching hospitals, and because managed research is increasing, managed medical education could become a reality as well. He explains why reorganizing medical education around professional values is crucial, why the AAMC's Medical School Objectives Project offers guidance in this area, why making this change will be difficult, and why medical education must lead in establishing how to document the presence and absence of such qualities as altruism and dutifulness and the ways that appropriate medical education can foster these and similar core competencies.

Hemmer PA,
Hawkins R, Jackson
JL, Pangaro LN.
Assessing how well
three evaluation
methods detect
deficiencies in medical
students'
professionalism in two
settings of an internal
medicine clerkship.
Acad Med.
2000; 75:167-73.

This study compares the performances of three evaluation methods in detecting deficiencies of professionalism among third-year medical students during their ambulatory care and inpatient ward rotations of a core internal medicine clerkship. The evaluation methods employed were standard checklists, written comments, and formal evaluation sessions. For each method, the authors found that deficiencies were twice as likely to be identified during the ward rotation as during the ambulatory care rotation. Another finding indicated that the face-to-face formal evaluation sessions yielded the most significant rate of detection of unprofessional behavior in both clerkship settings.

Henry RC, Wright
DE. When do medical
students become
human subjects of
research? The case of
program evaluation.
Acad. Med.
2001; 76:871-5.

The authors identify two factors that should be considered as institutions develop applications and interpretations of federal guidelines governing protection of research subjects. First, medical educators should enter into dialogues with their IRBs to become familiar with the regulations and their application in evaluation or assessment studies. Second, faculty should seek opportunities to model in their role as researchers those ethical behaviors that are central to an honest relationship between physician and patient.

Hensel WA, Dickey NW. Teaching professionalism: passing the torch.
Acad Med.
1998; 73:865-70.

Changes in medicine brought on by health care reform will increasingly pressure physicians and physicians-in-training to adopt business or trade strategies in the name of cost containment and of competition in the health care marketplace. These strategies run directly counter to the professional standards and are a potential threat to medicine's status as a profession. A challenge for this generation of students is not to let this emphasis on finances erode medicine's professionalism. Medical faculty must ensure that their students properly understand the nature of the relationships that permit medicine to enjoy the benefits of being a profession (rather than a trade) and that they learn the appropriate balance between financial and professional considerations.

Irvine D.
The performance of doctors: the new professionalism.
Lancet.
1999; 353:1174-7.

Concerted efforts are being made to find a modern expression of professionalism which should bring the public and the medical profession closer together. While the public appreciates what medical technology can achieve, the profession is seen as limited in its willingness and ability to communicate effectively, to act promptly to protect patients from poor practice, to be open about risks, and to admit to errors. The author examines the public's expectations and compares current trends in regulatory behavior to demonstrate the need for a new concept of professionalism in medicine.

Kalb PE.
Health care fraud and abuse.
JAMA.
1999; 282:1163-8.

In recent years, health care fraud and abuse have become major issues, in part because of the rising cost of health care, industry consolidation, the emergence of private "whistle-blowers," and a change in the concept of fraud to include an emerging concern about quality of care. As enforcement of health care fraud and abuse laws has become increasingly commonplace, the author examines these trends in depth.

Kassirer JP. Patients, physicians, and the internet. *Health Aff.* 2000; 19:115-23.

The Internet will have a profound effect on the practice and business of medicine. Physicians, eager to provide high-quality care and forced by competition to offer online services, will introduce e-mail and patient-friendly Web sites to improve administrative services and manage common medical conditions. Patients will identify more health information online and will take more responsibility for their care. The doctor/patient relationship will be altered: Some aspects of electronic communication will enhance the bond, and others will threaten it. Patients will have access to vast information sources of variable validity. Many physician organizations are preparing for the electronic transformation, but most physicians are unprepared, and many are resistant.

Kassirer JP. Pseudoaccountability. *Ann Intern Med.* 2001; 134:587-90.

The public has long entrusted the medical profession to regulate its own practices, but efforts to do so have been uneven. In place of rigorous, enforceable standards, we have sometimes reverted to pseudoaccountability: weak regulations that only give the appearance that we have been responsible in setting and enforcing high standards. Professional membership organizations must stop promulgating weak guidelines and offering evaluative methods to assess and regulate their own coveted members. Instead, they must turn over assessment of their members to arm's-length, disinterested groups.

Kuttner R. Managed care and medical education. *N Engl J Med.* 1999; 341:1092-6.

After a quarter century of relative plenty, academic medical centers find themselves in a serious financial squeeze that is beginning to compromise their triple mission of teaching, research, and clinical care. Teaching hospitals are no longer able to bill at rates that reflect the extra costs of their academic role, and most have sought to make up in patient volume what they have lost in income margins. This survival strategy, though a necessary response to the new environment, intensifies the constraints on teaching.

Larkin GL.
Evaluating professionalism in emergency medicine: clinical ethical competence.
Acad Emerg Med.
1999; 6:302-11.

While the teaching and assessing of technical skills have been an integral part of residency training, the demonstration of ethical and humanistic skills has been more or less left to chance. The few prospective evaluations of trainees have focused on single-researcher observations of student attitude surveys, and more reliable and valid methods are needed. This paper reviews a variety of evaluative tools and suggests a three-level approach to monitoring the ethical knowledge, capacity, and real-time performance of emergency medicine residents.

Leach DC.
Competence is a habit.
JAMA.
2002; 287:243-4.

This editorial examines the developmental process of skills acquisition, and its impact on the training and assessment of physicians.

Lehna C et al.
Nursing attire: indicators of professionalism?
J Prof Nurs.
1999; 15:192-9.

This study explores the effect that current nursing attire has on the image of the nursing profession. The authors aim to help nursing administrators and other health care professionals gain an understanding of the importance of attire as an indicator of nursing professionalism.

Lingard L, Garwood K, Szauter K, Stern D.
The rhetoric of rationalization: how students grapple with professional dilemmas.
Acad Med.
2001; 76:S45-7.

Medical educators have been relatively unsuccessful in evaluating and predicting professional behavior. The science of rhetoric provides formal analytic tools for excavating and analyzing students' reasoning strategies. The authors employ an approach of "social constructivism" which emphasizes how language embodies strategies for action. Students' stories of professional dilemmas are examined to determine their perceptions and constructions of their role within medicine.

Ludmerer KM.
Instilling professionalism in medical education.
JAMA.
1999; 282:881-2.

In recent years market forces have posed an unprecedented threat to medical professionalism – particularly the physician's obligation to serve the needs of patients. One significant method for redressing this is the incorporation of instruction about professionalism into the medical school curriculum. The author of this concise editorial addresses the debate over the efficacy of formal courses as a means to instill professionalism.

Ludmerer KM.
**Time to heal:
American medical
education from the
turn of the century to
the era of managed
care.**
*1999. New York:
Oxford University
Press.*

This widely acclaimed book provides a landmark account of American medical education throughout the twentieth century, and concludes with a call to reform a system handicapped by managed care and the loss of genuine professionalism.

**Markakis KM,
Beckman HB,
Suchman AL, Frankel
RM.**
**The path to
professionalism:
cultivating humanistic
values and attitudes in
residency training.**
Acad Med.
2000; 75:141-50.

Though few question the importance of incorporating professionalism and humanism in the training of physicians, traditional residency programs have given little direct attention to the processes by which professional and humanistic values, attitudes, and behaviors are cultivated. The authors discuss the underlying philosophy of their primary care internal medicine residency program, in which the development of professionalism and humanism is an explicit educational goal. They also describe specific components of the program designed to create a learner-centered environment that supports the acquisition of professional values.

Mechanic D.
**Managed care and the
imperative for a new
professional ethic.**
Health Aff. **2000;**
19:100-11.

Physicians complain about the growth of managed care structures and strategies and their effects on treatment autonomy and medical professionalism. Organizational changes and a competitive marketplace make the traditional view less relevant today. New concepts of professionalism are needed that recognize constraints and include patient advocacy within a framework of procedural justice, responsibility for population health, new patient partnerships, and participation in an evidence-based culture. Such changes require more focused efforts in medical education to support then new professionalism.

Mellinkoff S.
**Time to heal and the
future of U.S. medical
education.**
Acad Med.
1999; 74:1061-2.

This concise commentary touches upon the most significant changes which have affected modern medical education and the difficult challenges which must now be addressed.

Newton MJ.
Can ethical guidelines save our professionalism?
Ophthal.
1999; 106:213-4.

In this editorial, the author suggests that the current model of for-profit managed care is inherently incompatible with ethical conduct. Recent ethics guidelines can only slow a relentlessly downward ethical spiral. He calls for intensive lobbying of political players for more funding, and discussions with patients about the negative impacts of managed care, as the first steps towards reversing the decline in professional responsibility.

Papadakis MA, Loeser H, Healy K.
Early detection and evaluation of professionalism deficiencies in medical students: one school's approach.
Acad Med.
2001; 76:1100-6.

The authors discuss an innovative system established at the University of California, San Francisco, School of Medicine which monitors and strives to provide remediation for students demonstrating unprofessional behavior

Papadakis MA et al.
A strategy for the detection and evaluation of unprofessional behavior in medical students.
Acad Med.
1999. 74:980-90.

The authors describe the experience of a prominent university with an evaluation system designed to monitor students' professional behaviors longitudinally through their clinical rotations.

Pawlson LG and O'Kane ME.
Professionalism, regulation, and the market: impact on accountability for quality of care
Health Aff.
2002; 21:200-7.

This paper examines the interplay of professionalism, regulation, and the market in shaping accountability on the part of hospitals, physicians, and health plans. The authors pay particular attention to the role of accreditation.

**Pellegrino ED,
Relman AS.
Professional medical
associations: ethical
and practical
guidelines.
JAMA. 1999.
282:984-6.**

Physicians must choose more definitively than ever whether their professional associations will assert the primacy of ethical commitment or shed any pretense of being moral enterprises and, instead, allow economic considerations to dominate their policies. The authors assert that medical associations must be committed, first of all, to the welfare of the sick, even at some risk to the profession's collective pride and profit. They also suggest that a multitude of physicians would endorse membership in professional associations that demonstrate significant moral leadership.

**Prislin MD, Lie D,
Shapiro J, Boker J,
Radecki S. Using
standardized patients
to assess medical
students'
professionalism.
Acad Med.
2001;76:S90-2.**

Much energy has been directed toward defining competencies that reflect professionalism and in creating corresponding curricula that will foster learning in this domain. However, having instruments that can accurately measure the attainment of professionalism remains an elusive goal. This study examines the utility of patient-based assessments of professional characteristics.

**Relman AS.
Education to defend
professional values
in the new corporate
age.
Acad Med.
1998; 73:1229-33.**

The corporate transformation of medicine raises questions about the basic purposes and values of the profession and the physician's social role that have not been adequately considered in medical school and residency curricula. The author proposes that, to prevent medicine from becoming merely a technologic business, the medical profession will have to become more actively involved with other policymakers and representatives of the public in efforts to improve the health care system, while preserving professional and social values.

**Roberts LW et al. An
invitation for medical
educators to focus on
ethical and policy
issues in research and
scholarly practice.
Acad Med.
2001; 76:876-85.**

The authors explain why attention to issues of safeguards in education research and practice is likely to grow at academic health centers, yet maintain that these issues are neglected in the medical education literature. The authors discuss the implications of this for faculty, training institutions, students, editors, and peer reviewers.

Rothman DJ.
Medical professionalism focusing on the real issues.
N Engl J Med.
2000; 342:1284-6.

There is considerable interest in reinvigorating medical professionalism, but as the debate continues there are important issues that are never genuinely explored. While there is general agreement that a foremost principle of professionalism is the primacy of patients' interests over physicians' financial self-interest, several related questions are not typically addressed. These include how to reduce physicians' financial interests and better monitor their behavior, and generally implement and enforce professional standards. The author aims to refocus the debate on these kinds of crucial, oft-overlooked issues.

Sullivan WM.
What is left of professionalism after managed care?
Hastings Cent Rep.
1999; 29:7-13.

Modern American medicine has wedded scientific advance to a small business model of the individual practitioner, defining professionalism as technical understanding. If the profession is to survive, it must draw on older ideals of the learned professions as acting on behalf of the community, and reinvigorate an understanding of professional life.

Smith R.
Why are doctors so unhappy?
British Medical Journal.
2001; 322:1073-4.

The author examines several sources of physician unhappiness, including the business aspects of medicine, the regulatory environment, the disparity between skills taught in medical training and those required for successful practice, and the bogus social contracts that have long defined both physicians and patients' views of the healthcare system.

Sullivan WM.
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Modern American medicine has wedded scientific advance to a small business model of the individual practitioner, defining professionalism as technical understanding. If the profession is to survive, it must draw on older ideals of the learned professions as acting on behalf of the community, and reinvigorate an understanding of professional life.

Swick HM.
Academic medicine must deal with the clash of business and professional values.
Acad Med.
1998; 73:751-5.

There is an inherent clash of values between business and medicine, and insofar as business interests have already gained a central place in medicine, the challenge has become how to utilize the positive elements of the entrepreneurial spirit to enhance professional values and advance academic medicine's central enterprise. The author maintains that to achieve that synthesis, the leaders of academic medicine must continue to engage in a dialogue with the broader academic community, the government, the public, and the health care industry.

Swick HM, Szenas P, Danoff D, Whitcomb ME.
Teaching professionalism in undergraduate medical education.
JAMA.
1999; 282:830-2.

There is a growing consensus among medical educators that to promote the professional development of medical students, schools of medicine should provide explicit learning experiences in professionalism. The authors aim to determine whether and how schools of medicine were teaching professionalism during the 1998-99 academic year. They find that the teaching of professionalism varies widely, and although most programs address this topic in some manner, the strategies used may not always be adequate.

Swick HM.
Toward a normative definition of medical professionalism
Acad Med.
2000; 75:612-16.

The author asserts that there is no common understanding of what is meant by the word professionalism, and he thus proposes a normative definition which reflects societal expectations as they relate to physicians' responsibilities. He identifies nine behaviors that constitute medical professionalism, which physicians must exhibit if they are to meet their obligations to their patients, their communities, and their profession.

Tauber AI.
Putting ethics into the medical record.
Ann Intern Med.
2002; 136:559-63.

The medical record is a sensitive indicator of how care is administered, reflecting not only the structure of clinical thinking but also the values embedded in medical practice. Ostensibly, the medical record identifies all the existing clinical issues, assesses each individually, and then integrates these issues to ensure that the patient receives thorough care. But the aspiration toward integrated, comprehensive health care remains, and the medical chart continues to be piecemeal and incomplete. The author therefore proposes adding a section to the medical record addressing ethical concerns.

Wear D, Castellani B.
The development of professionalism: curriculum matters
Acad Med.
2000; 75:602-11.

The authors propose that professionalism, rather than being left to the chance that students will model themselves on ideal physicians or somehow be permeable to other elements of professionalism, is fostered by students' engagement with significant, integrated experiences with certain kinds of content. To educate broadly educated physicians who develop professionalism throughout their education and their careers requires a full-spectrum curriculum and the processes to support it. The authors sketch the ways in which admission, curriculum, assessment and licensure could function to maximize that end.

**World Medical Association.
World medical association declaration of helsinki: ethical principles for medical research involving human subjects.
JAMA.
2000; 284:3034-5.**

The World Medical Association has developed the Declaration of Helsinki as a statement of ethical principles to provide guidance to physicians and other participants in medical research involving human subjects. First adopted in 1964, these principles were amended for the fifth time in October 2000.

**Wynia MK et al.
Medical professionalism in society.
N Engl J Med.
1999; 341:1612-16.**

The authors undertake to clarify the concept of medical professionalism with a focus on the role of physicians in society. They present a model of professionalism that incorporates three elements: devotion to service, profession of values, and negotiation within society.

**Yao DC, Wright SM.
National survey of internal medicine residency program directors regarding problem residents.
JAMA
2000; 284:1099-1104.**

To gain more understanding of the prevalence, identification, management and prevention of problem residents within US internal medicine residency programs, the authors conducted a wide-ranging survey of program directors. They found that nearly all residency programs experienced problem residents, and the presenting characteristics and underlying issues were diverse and complex, indicating the need for further research.

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[National Study for Graduate Education in Internal Medicine \(NaSGIM\)](#)

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