Journal of Community Hospital Internal Medicine Perspectives

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EDITOR'S PERSPECTIVE

Professionalism: hard to measure but you know it when you see it

In 1992, the American Board of Internal Medicine (ABIM) convened a committee, which produced a white paper entitled Project Professionalism (1). John Stobo, chairman of The Johns Hopkins University Department of Medicine, chaired the committee. The paper emphasized values and ethics standards that would be required for board certification (2). It also pointed out that suboptimal professional behavior negatively impacted patient care.

In 2002, the ABIM combined with the American College of Physicians (ACP) and the European Federation of Internal Medicine to put forth a charter on professionalism for a new millennium (3). With the dawn of the Accreditation Council for Graduate Medical Education (ACGME) new accreditation process in 2013, there has been an increased emphasis on the documentation and proof of satisfactory professionalism for all residents in approved training programs in the United States (4).

For internal medicine program directors and teaching faculty, measuring and judging degrees of professionalism creates challenges in many ways more difficult and more subjective than assessing medical knowledge or procedural skills. Professionalism, or, acting like a professional, is at the heart of being a physician. Although other professions may claim professionalism as equally important, I do not believe there are any with higher standards than in medicine. Since Hippocrates (and no doubt before), it has been an unambiguous standard. So why should it be necessary to focus and work so hard for definitions and for it even to be a milestone? This is in part because of public demand, forcing medical educators to set specific standards.

What words describe medical professionalism? Words that come to mind include accountability, empathy, and responsibility. The health profession has a moral compass led by decency and altruism. It includes professional appearance when working; an indication of respect for the patient and their loved ones. In my observations at the bedside, professional appearance is usually more important to the family since they are likely feeling much better than the patient who has other issues. A sense of duty is the encompassing rubric. Professionalism means always trying to do the right thing, particularly when you are on your own making decisions in the middle of the night.

In this issue of the journal, Malakoff et al. have developed a novel approach to the challenges of assessing professionalism in residents in training (5). They commented that 'medical professionalism is complicated … and measurement is even more complex'. They developed an intriguing point system, both positive and negative for activities reflecting resident professionalism. Negative points were generated by individual negligent acts including tardiness, paperwork delays, and abuse of free time. Positive balancing points were acquirable for doing solicited or unsolicited scholarly work. The authors acknowledge that negative point system awareness may be heavily influenced by the Hawthorne Effect. Nevertheless, it seemed to work in this program to change behaviors and give the faculty something that was measurable and reproducible. This program was modeled in part by a program developed in Ireland (6). Faculty at this center used similar metrics and found it correlated well with the opinions of the faculty regarding the personal qualities of individual residents. This makes one wonder that if the traditional faculty observation of the trainee is the gold standard, why not use that? The most apparent reason for wanting something more than individual experienced opinions is that present day mores and accompanying reimbursement require quantitative measurement of everything in the medical profession. This novel system that sets standards could be helpful in its own right. It is something to build on. As the authors conclude, 'it is one way to help codify professional activities'. And at the very least, program directors would welcome a way to get residents to conferences on time and to do their discharge summaries.

I am a strong believer in the individual interview as a very important screening tool for professionalism in residency applicants. I estimate that I have conducted more than 5,000 one-on-one interviews in my years as an internal medicine program director. Similarly, John Talbott has pointed out the value of observation in the medical student selection process (7). My track record has been excellent. Careful review of personal statements written in the application followed by 20–30 min face-to-face has rarely failed me, as evidenced by the minimal number of problem residents in my program. I sacrifice specificity for sensitivity – if there were any doubts regarding potential professionalism after the interview, the individual did not make our NRMP match list.

I have been asked what exactly I look for. Body language is one thing, especially eye-to-eye contact or lack of it.

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Another is misrepresentation of facts in the application and the applicant's efforts to rationalize this. Most importantly, it is when a bell goes off indicating that I've seen this before. After all, there is a limit on how many personalities and characters exist. You make an educated guess and if you have been well-educated and pay attention, and are not influenced by a personal agenda, you will be right most of the time. Like other competency assessments, after a while, YOU DO KNOW IT WHEN YOU SEE IT.

Currently, I am a faculty member at Greater Baltimore Medical Center (GBMC) with primary responsibilities supervising resident teaching teams on the general medicine inpatient services. My direct bedside contact with the residents is extensive. Although this activity is not a major component of Malakoff's program mentioned earlier, it is unmatched in the potential value as an opportunity to judge professionalism. The finer points of patient interaction, respect and communication take place on a daily basis. Faculty role modeling is a great opportunity for teaching professionalism at the bedside. Real patients and real patient care issues, in my opinion, mean more and have a more lasting impact than simulation.

I am also working with medical students from the University of Maryland School of Medicine at two levels. For 8 years, I have precepted first- and second-year medical students in their Introduction to Clinical Medicine course (physical diagnosis). A school like Maryland recruits excellent students who are willing to strive for their respective professional growth. They are gratifying to work with, and, at the same time, inspiring. Just as with my GBMC residents, they make the mentor grow by challenging him or her. It is a great opportunity for emphasizing professionalism.

The second current University of Maryland contact is through a new initiative, which started at the school of medicine in 2013, entitled the Professionalism Enhancement Initiative. I serve as Physician Leader of this program and in this role will be working with all levels of medical students, years 1–3. There is a focus on third year clinical clerks in the critically important first experiences on the medical wards and clinics. Imprinting of future behavior as a medical trainee takes place in this period. At the University of Maryland, we believe that enhancing professionalism in the training periods can have an enduring effect and enhance the culture. This has been demonstrated in a recent report from Canadian Academic centers (8).

In this issue, there are four research articles in addition to Malakoff's. The scope of these studies point out the importance of scholarly activity by residents and faculty in the community hospital setting – the primary mission of JCHIMP. A multicenter study of low health literacy training was perceived by residents and students in training (9); a provocative prospective study funded by a state agency in one Baltimore community hospital using Suboxone to improve abstinence from heroin (10); a single center study using scripted standardized discussion regarding CPR status in 336 community hospital admissions (11); and a retrospective review of implantable defibrillators in 13 patients, providing a platform to improve utilization and resource allocation (12). In addition, there are four case reports: hypoglycemia after bariatric surgery (13); ulcerative colitis associated with ITP, successfully treated with anti-TNF therapy (14); acute kidney injury caused by reflex anuria (15); and pancytopenia related to Whipple's disease invasion of the bone marrow (16).

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