Advancing Education in

MEDICAL PROFESSIONALISM

*An **Educational Resource***
from the

ACGME
Outcome Project

Enhancing residency education
through outcomes assessment

ADVANCING EDUCATION IN MEDICAL PROFESSIONALISM

OVERVIEW

PURPOSE: To provide educational resources for program directors and other medical educators to aid teaching and assessing professionalism, one of the six ACGME general competencies

CONTENT:

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What is Professionalism?

PROFESSIONALISM

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

- demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development.
- demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities (ACGME, 1999)

Other Perspectives on Professionalism

Medical professionalism is the ability to meet the relationship-centered expectations required to practice medicine competently (Kuczewski et al., 2003; Lynch et al., in press; Surdyk et al., 2003).

Examples

**patient-physician relationship*: being careful and thorough when performing physical examination

**community-physician relationship:* participating in initiatives to improve health care safety

**health care system-physician relationship*: interacting respectfully with other health care providers

**physician-physician relationship:* taking time to teach medical students and residents

**self-physician relationship:* reflecting critically on own performance

Professionalism is based on the principles of primacy of patient welfare, patient autonomy, and social justice. It involves the following professional responsibilities: competence, honesty, patient confidentiality, appropriate relations with patients, improving quality of care, improving access to care, just distribution of finite resources, commitment to scientific knowledge, maintaining trust by managing conflicts of interest, commitment to professional responsibilities (ABIMF, ACP-ASIM, & EFIM, 2002).

Frequently Asked Questions about Professionalism

1. How does professionalism affect the patient-physician relationship?

- Professionalism is related to patient satisfaction. Patients are more likely to be satisfied with physicians who behave professionally.[1,2]
- Patients are more likely to follow through with treatment recommendations when they trust their physician (trust is a component of professionalism).[1,2]
- Patients say they are more likely to stay with physicians they perceive as behaving professionally and are likely to recommend these physicians to others.[1]
- Most patient complaints about physicians involve physicians' unprofessional behavior.[3]
- Patients are more likely to bring legal action against physicians they perceive as behaving unprofessionally than other physicians.[3]
- Evidence suggests a relationship between physician excellence and professionalism.[4]

2. How can I make professionalism more concrete for learners?

- Describe professionalism, or lapses of it, in terms of specific behaviors.[5]
- Categorize levels of professionalism and describe examples for each level. Larkin's categories are: Ideal (e.g., consistently goes beyond call of duty), expected (e.g., complete care and disposition of patients before signing them out), unacceptable (e.g., make passes at students or patients), egregious (e.g., falsify records).[6]
- Review professionalism scenarios (see Barry Challenges to Professionalism Questionnaire) and use these to prompt learner generation of other scenarios.[7]

3. Professionalism seems to be closely tied to an individual's personality, what evidence shows that professionalism can be changed?

With targeted, defined interventions, it is possible to change specific professional attitudes and beliefs,[8,9] reasoning,[10,11] and behaviors.[12,13]

4. How does the educational and working environment influence professionalism?

The educational environment, whether through formal or informal curricula, appears to influence learner attitudes and behavior.[14] One study discerned relationships between the ethical environment and medical students' ethical behavior.[15] In another study, residents reported learning most about professionalism from observing role models.[16] Furthermore, research suggests that business and cultural environments influence professionalism among practicing physicians.[17,18]

5. Regarding resident professionalism, what should I look for?

Consider important expectations for the medical profession and your specialty. For example, is the resident thorough and careful in completing patient care tasks? Does the resident know the limits of his or her abilities and ask for help when appropriate? Is the resident willing to help or fill-in for others? Is the resident respectful in his or her interactions with colleagues and other health care professionals?

References

1. Hall MA, Zheng B, Dugan E, Camacho F, Kidd KE, Mishra A, et al. Measuring patients; trust in their primary care providers. *Med Care Res Review* 2002; 59:293-318.
2. Hauck FR, Zyzanski SJ, Alemagno SA, Medalie JH. Patient perceptions of humanism in physicians: effects on positive health behaviors. Fam Med 1990;22:447-52.
3. Hickson GB, Federspiel CF, Pichert JW, et al. Patient complaints and malpractice risk. JAMA 2002;287:2951-7.
4. Baldwin DC, Bunch WH. Moral reasoning, professionalism, and the teaching of ethics to orthopedic surgeons. Clin Orthop 2000;378:97-103.
5. Ginsburg S, Regehr G, Hatala R, McNaughton N, Frohna A, Hodges B, et al. Context, conflict, and resolution: a new conceptual framework for evaluating professionalism. Acad Med 2000;75(10 suppl):S6-11.
6. Larkin GL. Mapping, modeling, and mentoring: charting a course for professionalism in graduate medical education. Camb Q Healthc Ethics 2003;12:167-77.
7. Barry D, Cyran E, Anderson RJ. Common issues in medical professionalism: room to grow. Am J Med 2000;108:136-42.
8. Hayes RP, Stoudemire A, Kinlaw K, Dell M, Loomis A. Changing attitudes about end-of-life decision making of medical students during third-year clinical clerkships. Psychosomatics 1999;40:205-9.
9. Tang TS, Fantone JC, Bozynski ME, Adams BS. Implementation and evaluation of an undergraduate sociocultural medicine program. Acad Med 2002;77:578-85.
10. Godkin M, Savageau J. The effect of a global multiculturalism track on cultural competence of preclinical medical students. Fam Med 2001;33(3):178-86.
11. Self DJ, Olivarez M. Retention of moral reasoning skills over the four years of medical education. Teach Learn Med 1996;8:195-9.
12. Beckman H, Frankel R, Kihm J, Julesza G, Geheb M. Measurement and improvement of humanistic skills in first-year trainees. J Gen Intern Med 1990;5:42-5.
13. Phelan S, Obenshain S, Galey WR. Evaluation of non-cognitive professional traits of medical students. Acad Med 1993;68:799-803.
14. Stern DT. Values on call: a method for assessing the teaching of professionalism. Acad Med 1996;71(10 suppl):S37-9.
15. Feudtner C, Christakis D, Christakis N. Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development. Acad Med 1994;69(8):670-9.
16. Brownell AKW, Cote L. Senior residents' views on the meaning of professionalism and how they learn about it. Acad Med 200l;76:734-7.
17. Freeman VG, Rathore SS, Weinfurt KP, Schulman KA, Sulmasy DP. Lying for patients: physician deception of third-party payers. Arch Intern Med 1999;159:2263-70.
18. Hoffmaster CB, Stewart MA, Christie RJ. Ethical decision making by family doctors in Canada, Britain, and the United States. Soc Sci Med 1991;33:647-53.

There is a broad scope of approaches to **Teaching Professionalism** in Graduate Medical Education

Examples

Example	*Method*	*Description*
Hospital to Home Program *Matter CA, Speice JA, McCann R, Mendelson DA, McCormick K, Friedman S, et al. Hospital to home: Improving internal medicine residents' understanding of the needs of older persons after a hospital stay. Acad Med 2003;78:793-7.*	CLINICAL/ EXPERIENTIAL	Each resident visits a patient post-discharge to aid their understanding of patient functioning and related psychosocial issues in other settings. This information helps to determine how well discharge recommendations can be met *
Role play with simulated patients *Culhane-Pera KA, Reif C, Egli E, Baker NJ, Kassekert R. A curriculum for multicultural education in family medicine. Fam Med 1997;29:719-23.*	SIMULATION	Following a seminar on cross-cultural patient-centered communication, each resident practices interaction skills with three simulated patients from different ethnic and/or religious backgrounds*
Challenging case conference *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.*	DISCUSSION/ SEMINAR	Residents meet to discuss and receive feedback on challenging psychosocial issues that occur during their care of patients
Leadership training *Kuczewski KG, Bading E, Langbein, M, et al. Fostering professionalism: the Loyola model. Camb Q Healthc Ethics 2003;12:161-6.*	COOPERATIVE/ TEAM LEARNING	To develop leadership skills and promote excellence, physicians, residents, and medical students work in teams to identify and address care delivery problems
Cultural sensitivity presentations *Rosenfeld JC, Sefcik S. Utilizing community leaders to teach professionalism. Curr Surgery 2003;60:222-4.*	LECTURE	Community members, e.g., clergy, ethicists, humanities faculty, discuss professionalism issues with surgery residents and other health care providers
Web-based curriculum *Huggett JM, Snyder KE, Gay SB, Jackson J, Mackey A. A web-based system of instruction and self-evaluation in patient confidentiality and informed consent. Poster presented at the 2003 ACGME Annual Educational meeting, Chicago, March 5-7, 2003.*	INDEPENDENT LEARNING	Information about informed consent and confidentiality is presented on-line, followed by quizzes with vignettes

*See next page for more information about this approach

Hospital to Home Program

Goal: Expand resident understanding of patients and their care in a range of settings

What happens?

The resident follows a patient (who has consented to participate) from discharge to about one week post-discharge and completes the following activities.

- Conducts a pre-discharge assessment (e.g., activities of daily living assessment, social support history, medication management plans)
- Obtains input from patient's family and other involved health care providers
- Visits patient at home or at other setting and completes assessment (e.g., safety, social support, functional status)
- Presents discharge plan and home visit findings (includes videotape) to other residents and faculty
- Discusses improvements to discharge plan with group and identifies learning points

How does this program address professionalism?

- Aids resident understanding of the patient (e.g., feasibility of implementing discharge recommendations)
- Helps the resident to develop his or her relationship with the patient and their families
- Advances resident's relationship with other involved health care providers
- Provides the resident a structured opportunity to reflect on and judge their discharge recommendations

Multicultural Curriculum

Goals: Help residents to, 1) gain insight into how culture influences them in their personal and professional lives, 2) appreciate how culture influences patients' perspectives on health, disease, and healing processes, 3) develop multicultural communication skills to improve patient care

What happens?

Clinical teaching

Using real-time patient encounters and videotaped encounters, faculty help residents to identify multicultural issues involved in patient care, explore residents' emotions and beliefs pertinent to the encounter, and discuss relevant communication skills.

Didactic

Conferences, grand rounds, and three annual day-long cultural awareness and reflection seminars address interaction skills and how culture influences health, disease, and treatment, and how residents can understand their own cultural beliefs and values. Methods used included case discussions, role-plays with simulated patients, community member presentations, videotapes, and lectures.

How does this program address professionalism?

- Aids resident understanding of diverse patients
- Helps the resident to interact with diverse patients
- Helps the resident to be effective with diverse patients
- Helps the resident to examine his or her own values and beliefs
- Helps the resident to develop skills needed for difficult medical encounters

Assessing Professionalism: System Considerations

WHY assess professionalism?

* To gauge learner abilities (to aid teaching and learning and determine achievement)
* To aid program and curriculum improvements

WHAT should be assessed?

* Important and representative expectations per specialty and developmental level
* Affective, cognitive, behavioral, environmental outcomes
* Five types of relationships (patient, society, physician, health care system, self)

HOW should professionalism be assessed?

* Use methods that are congruent with objectives
* Use more than one method (e.g., 360° & vignettes)
* Use methods likely to yield valid and reliable data

WHO should assess professionalism?

* Different types of assessors (e.g., physicians, other health care professionals, patients)
* Invested assessors who are willing to be trained or have relevant experience

WHEN should professionalism be assessed?

* Begin early
* Conduct frequently over the long-term
* Before and after teaching or improvement opportunities

WHERE should professionalism be assessed?

* Multiple settings (e.g., inpatient, outpatient, community)

There is a broad scope of approaches to **Assessing Professionalism** in Graduate Medical Education

Examples

Example	*Method*	*Description*
Hickson Codes *Hickson GB, Federspiel CF, Pichert JW, et al. Patient complaints and malpractice risk. JAMA 2002;287:2951-7.* Holleran Chart Abstraction Protocol *Holleran S, Starkey G, Burke P, Steele G, Folse R. An educational intervention in the surgical intensive care unit to improve ethical decisions. Surgery 1995;118(2):294-8.*	RECORDS/ PERMANENT PRODUCTS	Patient complaints coded into categories of professional behavior Charts reviewed for evidence that selected ethical issues were addressed by residents
Transitional Visit Skills Assessment *Beckman H, Frankel R, Kihm J, Julesza G, Geheb M. Measurement and improvement of humanistic skills in first-year trainees. J Gen Intern Med 1990;5:42-5.* *Stern Value Code* *Stern DT. Values on call: a method for assessing the teaching of professionalism. Acad Med 1996;71(10 suppl):S37-9.*	OBSERVATION AND RECORDING	Videotapes of resident interactions with patients during transition visits rated by using a 9-item checklist Physicians' professional behaviors observed by trained observers and analyzed using 37 qualitative codes
Barry Challenges to Professionalism Questionnaire *Barry D, Cyran E, Anderson RJ. Common issues in medical professionalism: room to grow. Am J Med 2000;108:136-42*	COGNITIVE TEST	Residents select the best response to scenarios depicting professionalism issues*
Musick 360° Evaluation *Musick DW, McDowell SM, Clark N, et al. Pilot study of a 360-degree assessment for physical medicine & rehabilitation residency programs. Am J Phys Med Rehabil 2003;82:394-402.* Wake Forest Physician Trust Scale Hall MA, Zheng B, Dugan E, Kidd KE, Mishra A, Balkrishnan R, Camacho F. Measuring Patients' Trust in Their Primary Care Providers. Med Care Res Review 2002 Sep;59(3):293-318	SURVEY/ RATING	Therapists, nurses, social workers, case managers, and psychologists assess residents using the same performance rating form* Patients use this form to rate physician professionalism and patient care*

* See next page for more information about this instrument, permission has been granted for its use

The Wake Forest Physician Trust Scale

What is it?

The Wake Forest Physician Trust Scale is a 10-item rating form that measures physician professionalism and patient care skills. Patients rate each item on a 5-point scale ranging from strongly disagree (1) to strongly agree (5) and can complete the form at any time since it does not pertain to a specific encounter.

How may it be used?

Information obtained from the Wake Forest Physician Trust Scale may be used to provide residents formative feedback about professionalism and selected patient care skills.

Benefits of this method

The Wake Forest Physician Trust Scale collects data from the perspective of the patient and is relatively easy to complete. Extensive pilot research has indicated that it yields valid and reliable data. A short form (i.e., 5 items) of the scale has also been developed.

Disadvantages of this method

Stable estimates of performance may require forms from several patients per physician. Also, it may be difficult to obtain a reasonable response rate from patients.

Wake Forest Physician Trust Scale

After reading each statement, please circle how much you agree or disagree with each statement.

1. [Your doctor] will do whatever it takes to get you all the care you need. **Strongly Agree Agree Neutral Disagree Strongly Disagree**
2. Sometimes [your doctor] cares more about what is convenient for [him/her] than about your medical needs. **Strongly Agree Agree Neutral Disagree Strongly Disagree**
3. [Your doctor] 's medical skills are not as good as they should be. **Strongly Agree Agree Neutral Disagree Strongly Disagree**
4. [Your doctor] is extremely thorough and careful. **Strongly Agree Agree Neutral Disagree Strongly Disagree**
5. You completely trust [your doctor's] decisions about which medical treatments are best for you. **Strongly Agree Agree Neutral Disagree Strongly Disagree**
6. [Your doctor] is totally honest in telling you about all of the different treatment options available for your condition. **Strongly Agree Agree Neutral Disagree Strongly Disagree**
7. [Your doctor] only thinks about what is best for you. **Strongly Agree Agree Neutral Disagree Strongly Disagree**
8. Sometimes [your doctor] does not pay full attention to what you are trying to tell [him/her] **Strongly Agree Agree Neutral Disagree Strongly Disagree**
9. You have no worries about putting your life in [your doctor] 's hands. **Strongly Agree Agree Neutral Disagree Strongly Disagree**
10. All in all, you have complete trust in [your doctor]. **Strongly Agree Agree Neutral Disagree Strongly Disagree**

Note 1: Used with permission from Mark A. Hall, J.D., Wake Forest University School of Medicine, Department of Public Health Sciences.

Note 2: From "Hall MA, Zheng B, Dugan E, Kidd KE, Mishra A, Balkrishnan R, Camacho F. Measuring Patients' Trust in Their Primary Care Providers. Med Care Res Review 2002 Sep;59(3):293-318."

ABIM Scale to Measure Professional Attitudes and Behaviors in Medical Education

What is it?

The Scale to Measure Professional Attitudes and Behaviors in Medical Education (SMPABME) is a self-administered questionnaire that consists of 12 items, each rated on a 9-item scale from never (1) to always (10).

How may it be used?

The SMPABME obtains respondents' opinions about professionalism in their educational environment. Since the items ask the respondent to report on the behaviors of others (versus the respondent's own behavior), it can be used to obtain information about sensitive professionalism areas (e.g., deception) that respondents may be unwilling to report about themselves, thus it can give information about program-wide behaviors. The SMPABME may be used to gauge the effect of program-wide interventions that address professionalism areas.

Benefits of this method

The SMPABME can be used to obtain information about sensitive professionalism areas (e.g., deception) and provides information about program-wide behaviors. With only 12 items, the SMPABME is easy to administer. Construct validity of the SMPABME may be inferred from a factor analysis which indicated that it measured excellence, honor/integrity, and altruism/respect. The inter-item reliability of the SMPABME is 0.71.

Disadvantages of this method

The SMPABME can not be used to gauge the behavior of individual learners. Also, it focuses mostly on the behavior of other residents. Information about the behavior of other important people in the learners' environment (e.g., supervising physicians, nurses, laboratory staff) would provide more accurate information about the educational environment.

ABIM Scale to Measure Professional Attitudes and Behaviors in Medical Education

The following survey is designed to elicit the experiences residents in internal medicine have during their training that affect their professionalism. Therefore, your participation is greatly appreciated. Please complete the survey and return it to your program director expeditiously. Thank you.

Age: _____ Sex: ? Female ? Male

Check (Y) level of training that applies: PGY1 ? PGY2 ? PGY3 ? PGY4 ?

Indicate (Y) your immediate career goal:
? primary care practice ? undecided
? academic general internal medicine
? subspecialty training: Area _____
? other (describe) _____

Indicate (Y) the average number of hours per week that you commit to your training (including formal rotations, teaching conferences, clinics, on call, reading):

? 50 – 60 hrs ? 61- 70 hrs ? 71 – 80 hrs ? 81 – 90 hrs ? > 90 hrs

For the following questions, circle the rating that applies (1=never, 9=always).

1. During this residency training, I have met individuals whom I consider role models.

Never 1 2 3 4 5 6 7 8 9 Always

2. During residency training, I have encountered individuals on clinical rotations who display and promote professional behavior.

Never 1 2 3 4 5 6 7 8 9 Always

3. My resident colleagues have assisted me in attaining educational materials (e.g., journal articles, textbooks) pertaining to my patients.

Never 1 2 3 4 5 6 7 8 9 Always

4. I have observed that my resident colleagues place the needs of their patients ahead of their own self-interests.

Never 1 2 3 4 5 6 7 8 9 Always

5. I have observed that the residents I have worked with educate their patients about their illnesses.

Never 1 2 3 4 5 6 7 8 9 Always

6. I have been instructed to withhold data from a patient's chart without being given an explanation from my senior resident or attending physician.

Never 1 2 3 4 5 6 7 8 9 Always

7. I have observed my resident colleagues lie to a patient.

Never 1 2 3 4 5 6 7 8 9 Always

8. The residents I have worked with ask me to write orders or fill out forms and sign their name to them.

Never 1 2 3 4 5 6 7 8 9 Always

9. I have been urged by my resident colleagues to copy their history and physical exam rather than gathering my own information from the patient.

Never 1 2 3 4 5 6 7 8 9 Always

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10. I have observed resident colleagues referring to patients as "hits, gomers, real citizens, walkie-talkies, players, frequent flyers" or other terms.

Never 1 2 3 4 5 6 7 8 9 Always

11. I have observed my resident colleagues making derogatory statements about other medical/surgical specialists or specialty groups, subspecialists or subspecialty groups, or other health care professionals.

Never 1 2 3 4 5 6 7 8 9 Always

12. I have observed resident colleagues scheduling tests or performing procedures at times that are more convenient for themselves than for the patient.

Never 1 2 3 4 5 6 7 8 9 Always

Note: From "Arnold E, Blank L, Race K, Cipparrone N. Can professionalism be measured? The development of a scale for use in the medical environment. Acad Med 1998;73:1119-21."

Musick 360-degree Assessment

What is it?

A 360-degree assessment involves evaluation by several different types of raters who interact with those being assessed during the course of work or education. The Musick 360-degree Assessment is a questionnaire that has been completed by therapists, social workers, nurses, psychologists, and case managers. The recommended structure for a 360-degree assessment instrument is a set of items that will be completed by all evaluators plus subsets of items specific to evaluator groups. The Musick 360-degree Assessment consists of 26 items, each rated on a 9-item scale from unsatisfactory (1) to superior (9).

How may it be used?

The Musick 360-degree Assessment obtains evaluators' opinions about residents' abilities in the areas of professionalism, interpersonal and communication skills, and patient care. The results could initially be used as formative feedback, but used later to make a judgment about residents' abilities in the forementioned areas after they have had opportunities to address shortcomings. Electronic data collection and aggregation is strongly recommended. Phasing-in involvement of different evaluator groups would also make this assessment more feasible.

Benefits of this method

A 360-degree assessment provides different perspectives on resident abilities and allows comparison between, for example, self-evaluations and those obtained from peers and supervisors. Using multiple evaluators can help to increase data validity and reliability. Content validity of Musick's 360^{o} assessment could be inferred from the process by which the form was developed which involved a literature review and input from several staff.

Disadvantages of this method

One disadvantage of a 360-degree assessment is the potentially large number of evaluators needed before a stable estimate of performance is obtained for any evaluator group. This requirement poses a significant administrative challenge for the collection and collation of results. With regard to Musick's 360^{o} assessment, there is no information to date about the number of raters needed to provide reliable data.

Musick 360-degree Assessment

University of Kentucky College of Medicine, Department of Physical Medicine & Rehabilitation

Resident Interaction with Interdisciplinary Team Members Inpatient Rehabilitation Rotations

Resident's Name: _____ Date of Evaluation: _____

Rotation (circle one): GRU SCI TBI CVA Dates of Rotation: _____

Evaluator's Name (optional): _____

INSTRUCTIONS: Estimate ability for each item* listed. Please evaluate on the basis of your standards for expected performance and resident's knowledge at the current level of training. Circle the most applicable rating (1 through 9). Please check the "N/A" column if you are unable to rate the resident on that item, or if it does not apply.

	N/A or Unable To Rate	Unsatisfactory	Satisfactory	Superior
1. Overall competence/performance	____	1 2 3	4 5 6	7 8 9
2. Clinical judgment/clinical decision making	____	1 2 3	4 5 6	7 8 9
3**. Leadership skills**	____	1 2 3	4 5 6	7 8 9
4. Application of medical knowledge	____	1 2 3	4 5 6	7 8 9
5. Examination skills	____	1 2 3	4 5 6	7 8 9
6. Diagnostic skills	____	1 2 3	4 5 6	7 8 9
7. Documentation	____	1 2 3	4 5 6	7 8 9
8. Education of patient and family.				
9. Participation/supervision of all aspects of treatment	____	1 2 3	4 5 6	7 8 9
10. **Dependability/sense of responsibility**	____	1 2 3	4 5 6	7 8 9
11. **Sensitivity/compassion**	____	1 2 3	4 5 6	7 8 9
12. **Initiative**	____	1 2 3	4 5 6	7 8 9
13. **Organizational skills**	____	1 2 3	4 5 6	7 8 9
14. **Management skills**	____	1 2 3	4 5 6	7 8 9
15. **Respect for others**	____	1 2 3	4 5 6	7 8 9
16. **Self-confidence**	____	1 2 3	4 5 6	7 8 9
17. **Promptness**	____	1 2 3	4 5 6	7 8 9
18. **Receptivity to criticism**				
19. Rapport with nonphysician personnel	____	1 2 3	4 5 6	7 8 9
20. Rapport with patients and families	____	1 2 3	4 5 6	7 8 9
21. General interpersonal skills	____	1 2 3	4 5 6	7 8 9
22. Clarity of communication	____	1 2 3	4 5 6	7 8 9
23. Frequency of communication	____	1 2 3	4 5 6	7 8 9
24. **Collaboration/goal setting**	____	1 2 3	4 5 6	7 8 9
25. **Attendance at meetings**	____	1 2 3	4 5 6	7 8 9
26. **Participation in meetings**	____	1 2 3	4 5 6	7 8 9

**professionalism items are in bold type*

Note 1: Used with permission from David Musick, PhD, University of Kentucky College of Medicine, Department of Physical Medicine & Rehabilitation

Note 2: From "Musick DW, McDowell SM, Clark N, Salcido R. Pilot study of a 360-degree assessment instrument for physical medicine & rehabilitation programs. Am J Phys Med Rehabil 2003;82:394-402."

Barry Challenges to Professionalism Questionnaire

What is it?

The Barry Challenges to Professionalism Questionnaire (BCPQ) is a self-administered questionnaire that consists of six vignettes which portray challenges to medical professionalism. For each vignette, there are four response options. Respondents must select the option that most closely reflects their approach to addressing the challenge.

How may it be used?

The BCPQ is used to measure learners' cognitive responses to selected professional challenges. It may also be used to stimulate discussion about professional issues.

Benefits of this method

The BCPQ addresses contemporary professional issues. It is sensitive to different levels of experience; practicing physicians have performed better than residents who, in turn, have performed better than medical students, thus providing some evidence for construct validity. The BCPQ is relatively easy to administer.

Disadvantages of this method

The BCPQ addresses the cognitive aspects of professionalism only, thus it should be paired with another method that addresses professional behavior. With only six vignettes, it addresses a limited scope of medical professionalism issues. Content validity could be improved by increasing the number of scenarios. There is no information about reliability.

Barry Challenges to Professionalism Questionnaire

Please read the following cases. Recognizing that there may be other approaches, select the single best answer from those listed.

1. A pharmaceutical company approaches you about a clinical research project involving your office patients. Your patients with high blood pressure will be eligible to be treated with a new medication that has just been released by the FDA. The object of the study is to evaluate risks and benefits of this medication in an unselected office population. The pharmaceutical company will pay $250 per patient for the expenses generated by the study, and one year's salary for a data manager and will supply the drug free of charge. Meetings to discuss the initiation of the study and follow-up results will be held in New Orleans and Honolulu. Your spouse will be invited as the company's guest to attend these meetings since they will take you away from home.
Participating in the study would be considered appropriate professional behavior if:

A. Your patients signed an informed consent.
B. Your patients sign an informed consent and your partners approve the study.
C. An oversight committee of the hospital where you have privileges or your regional medical society approves the study.
D. None of the above.

2. You are practicing hematology and oncology in a suburb of a large metropolitan area. Currently, you refer your patients who require radiotherapy to one or two hospitals in the city depending on where the patients live and the type of problem. A radiotherapist whose knowledge and skill you respect informs you that she will be joining a for-profit national radiotherapy company that is thinking of locating in your area. This new company will bring both the latest equipment and up-graded service to your community. She informs you that an excellent opportunity now exists to invest in this company and that the larger the number of investors from the area, the greater the likelihood the company will locate the unit in your community.
Which of the following statements most accurately assesses the possibility of conflict of interest regarding your investment in this company?

A. An investment will pose a conflict of interest and you should not make it.
B. Your investment will pose no conflict of interest because the new radiotherapy unit will offer superior treatment and will be available to your patients.
C. There is a possibility of conflict of interest that requires that you inform your patients of the investment.
D. Your investment will pose no conflict of interest if you avoid referring your patients to the new radiotherapy unit.
E. There will be no problem of conflict of interest for you if the investment is made by your spouse.

3. A friend's 16-year-old daughter visits your office requesting birth control pills. Her family is Catholic and against birth control and premarital sex. She requests you do not discuss this with her parents. After concluding the visit, you return to your desk where you find a message to call the patient's mother. In the past you have always discussed the daughter's health and concerns openly. What will you do?

A. Call the mother back and disclose the reason for her daughter's visit.

B. Return the call and tell the patient's mother you can't discuss the matter, knowing this will look suspicious to her.
C. Return the call but be evasive when questioned about the nature of the visit.
D. Don't return the call.

4. You are the chief of service at a hospital and a medical student informs you that she smelled alcohol on the breath of an attending physician during morning rounds on more than one occasion. This report is confirmed by another student and a resident. How do you proceed?

A. Approach the physician in question and ask if he/she has a drinking problem.
B. Talk to friend and family members of the physician to see if they suspect a drinking problem.
C. Review the physician's file and monitor him/her closely.
D. Report the physician to the Colorado State Board of Medical Examiners.

5. During your rounds with the housestaff team, a male staff member comes up to the group, places his arm around the waist of a female house officer, and thanks her for the terrific job she did she did taking care of one of his patients. You sense that the house officer is made uncomfortable by the gesture. An appropriate first response would be which of the following?

A. Do nothing, on the basis that the faculty member was simply showing his appreciation for a job well done.
B. Report the incident to the program director as an example of sexual harassment.
C. Tell your colleague, the faculty member, that you thought the gesture was inappropriate and that you were made uncomfortable by it.
D. Ask the resident if the gesture made her uncomfortable.
E. Ask the resident if there are actions she would like you take on her behalf.

6. An established patient of yours presents with symptoms of depression. This is the second time in three months that the patient has visited you for these complaints. You wish to start treatment with anti-depressant medication. As you are filling out the prescription, the patient asks you not to document the diagnosis or medication in the chart. She is concerned that her employer will find out about her diagnosis and she could potentially lose her job like a coworker did. She knows that her insurance company has access to her diagnosis. How do you proceed?

A. Inform the patient that you must document the diagnosis to provide any treatment.
B. Agree to not document the diagnosis but prescribe the medication anyway.
C. Agree to not document the diagnosis but refuse to provide the prescription.
D. Terminate your relationship with the patient because she is inhibiting your ability to provide adequate care.
E. Document an alternative diagnosis, such as fatigue, and provide the prescription.

PROFESSIONALISM

ACGME Web-based Resource Guide

WHAT?	*WHERE?*
RSVP Learn about initiatives underway at programs and institutions to integrate the teaching and assessment of professionalism into GME curricula.	www.acgme.org/outcome/implement/rsvp.asp
Assessment Toolbox Find out about the characteristics of various methods of assessment.	www.acgme.org/outcome/assess/toolbox.asp
Example Assessments Identify specific tools that may be used to assess professionalism, including some practical and technical features of each.	www.acgme.org/outcome/assess/profIndex.asp
Think Tank Recommendations for Assessing Professionalism Read about approaches to assess professionalism recommended by the RRC Outcome Project Think Tank, which is an ad hoc advisory group whose purpose is to facilitate implementation of outcomes assessment according to ACGME program requirements.	www.acgme.org/outcome/project/thinktank.asp
References (i) Scan references related to the theory/concepts/rationale and the teaching and learning of professionalism	www.acgme.org/outcome/comp/refProf1.asp
(ii) Scan references related to assessing professionalism	www.acgme.org/outcome/assess/refList.asp#prof

PROFESSIONALISM

Specialty-specific Web-based Resource Guide

SPECIALTY ORGANIZATION	*WHERE?*
American Academy of Orthopaedic Surgeons	www.aaos.org/wordhtml/papers/ethics/prin.htm
American Board of Psychiatry and Neurology	www.abpn.com/geninfo/competencies.html
American Board of Internal Medicine Foundation	www.abimfoundation.org/pdf/ABIM_Charter_Ins.pdf
American Board of Pediatrics	www.abp.org/resident/profguid.htm
Association of Program Directors in Radiology	www.apdr.org/directors/general_competencies.htm
Society for Academic Emergency Medicine	www.saem.org/model/ethics.htm

Other References

American Board of Internal Medicine Foundation, American College of Physicians, European Foundation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. Ann Intern Med 2002;136:243-6.

Arnold L. Assessing professional behavior: yesterday, today, and tomorrow. Acad Med 2002;77:502-15.

Ginsburg S, Regehr G, Hatala R, McNaughton N, Frohna A, Hodges B, et al. Context, conflict, and resolution: a new conceptual framework for evaluating professionalism. Acad Med 2000;75(10 suppl):S6-11.

Gruen RL, Arya J, Cosgrove EM, Cruess RL, Cruess SR, Eastman AB, et al. Professionalism in surgery. J Am Coll Surg 2003;197:605-8.

Kuczewski KG, Bading E, Langbein, M, Henry B. Fostering professionalism: the Loyola model. Camb Q Healthc Ethics 2003;12:161-6.

Lynch DC, Surdyk PM, Eiser, A. Assessing professionalism: a review of the literature. Med Teacher, in press.

Surdyk PM, Lynch DC, Leach DC. Professionalism: identifying current themes. Curr Opin Anaes 2003;16:597-602.