Transforming Educational Accountability in Medical Ethics and Humanities Education Toward Professionalism

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Abstract

Effectively developing professionalism requires a programmatic view on how medical ethics and humanities should be incorporated into an educational continuum that begins in premedical studies, stretches across medical school and residency, and is sustained throughout one’s practice. The Project to Rebalance and Integrate Medical Education National Conference on Medical Ethics and Humanities in Medical Education (May 2012) invited representatives from the three major medical education and accreditation organizations to engage with an expert panel of nationally known medical educators in ethics, history, literature, and the visual arts. This article, based on the views of these representatives and their respondents, offers a future-tense account of how professionalism can be incorporated into medical education.

The themes that are emphasized herein include the need to respond to four issues. The first theme highlights how ethics and humanities can provide a response to the dissonance that occurs in current health care delivery. The second theme focuses on how to facilitate preprofessional readiness for applicants through reform of the medical school admission process. The third theme emphasizes the importance of integrating ethics and humanities into the medical school administrative structure. The fourth theme underscores how outcomes-based assessment should reflect developmental milestones for professional attributes and conduct. The participants emphasized that ethics and humanities-based knowledge, skills, and conduct that promote professionalism should be taught with accountability, flexibility, and the premise that all these traits are essential to the formation of a modern professional physician.

Since 1998, scholarly and educational accreditation organizations have stressed the fundamental importance of professionalism in medical education. Promoting professional development is central to the mission of medical schools and residency programs, as reflected in its promotion and evaluation by the Association of American Medical Colleges (AAMC), the Liaison Committee on Medical Education (LCME), and the Accreditation Council for Graduate Medical Education (ACGME). The Project to Rebalance and Integrate Medical Education (PRIME), formed in 2009, has forged a coalition of medical educators, administrators, and accreditors from these three organizations to promote ongoing discussion on medical education reform. Since its inception, PRIME has stimulated collaboration and elucidated the role of medical ethics and humanities in professionalism formation.

We will refer to PRIME’s prior works on medical education activities that fit into the rubric of “medical ethics and humanities.” We have previously articulated a framework of four broad areas of knowledge and skills that we believe are an integral part of medical education at all levels: argument-based reasoning in medical ethics (including the contributions of the disciplines of law, anthropology, and sociology); narrative-based reasoning in literature; creative reasoning in the fine arts; and, historical reasoning in learning. These knowledge and skills cultivate critical thinking skills required in health care practice. Mentors complement this process by modeling professionalism in patient-centered care.

The open-invitation PRIME National Conference on Medical Ethics and Humanities in Medical Education, “Reforming Ethics & Humanities Teaching in Medical Education: Fulfilling the Future Accreditation Goals on Professionalism,” was held May 10 and 11, 2012, in Louisville, Kentucky. Discussions on how—and whether—to frame outcomes-based education in medical ethics and humanities (particularly regarding the promotion of professionalism) was a major theme, especially given the difficulty of assessing such outcomes in varied contexts. Our proposed solution is that professionalism must be taught and assessed using an outcome-based framework. The outcomes of teaching professionalism must extend to behavioral change (i.e., learners translating their knowledge and skills into behavioral change) and results (e.g., enhanced patient care, interprofessional conduct, reduced errors). To make these points, we must first address “Why” and “Why now?”

Formation of the medical professional, as noted in our prior work, requires three essential commitments of each physician. First, establish competence by cohering to rigorous and accountable evidence-based medicine. Second, use this knowledge and skill set “to protect and promote the patient’s health-related interests as the physician’s primary concern and motivation, keeping self-interest systematically secondary.” Third,
adhere to and entrust the knowledge, skills, and virtues of medical care to future generations of “physicians, patients and society as a public trust," eschewing self-interest.8

Since 1999, there has been a shift in the professionalism discussion regarding medical education. Constructs have been advanced that attempt to translate professionalism formation into outcomes-based end points.10,11 These efforts use a virtue-based approach coupled with discrete behavioral expectations in patient-centered care.2,11 This is a response to increasing pressures for accountability by accreditation organizations and others with the need to demonstrate that funding provided to education results in quality physicians.2,3 All U.S. medical schools and residencies must satisfy these accreditation requirements. We recognize the competencies-based account of professionalism, and also reaffirm the knowledge, benefit, and trust commitments noted previously on medical professionalism, as these approaches are not contradictory. The PRIME national conference stressed the need for open-mindedness in educational processes regarding professionalism. There is no singular way to teach or assess the learner.12 Instead, diversity in pedagogical goals, processes, and outcomes is expected and desired.

The Foundation of Reform

Prominent aspects of the financing and delivery of health care in the United States create dissonance with the moral precepts taught to trainees during professional training. The current deficiencies of the U.S. system also illuminate severe challenges for physicians to live up to our ethical obligations as health care professionals because the current system often fails to attain “social justice” in health care.13

The United States suffers from inequities in health care outcomes by region, gender, ethnicity, socioeconomic status, and insurance status. As the United States implements the Affordable Care Act (ACA), it appears that the percentage of uninsured Americans is falling, but the most recent figures from the Kaiser Family Foundation show that more than 47 million people in the United States were uninsured in 2012.14,15 The United States is near the bottom of industrialized nations in life expectancy, with extremely high infant mortality and adult obesity rates (resulting in increased chronic disease prevalence).16,17

With these poor outcomes, the United States far outsends other nations, using 17.6% of its gross domestic product on health care.19 The United States paradoxically designates less to spend on nonmedical programs, such as services for the hungry and desperately impoverished, which could mitigate some of the negative foundational health factors.16 The U.S. health care system is at a tipping point of unsustainability. With the ACA's implementation, this is a moment for reflecting on accountability, not just in fiscal terms, but also with respect to the moral enterprise that is core to the practice of medicine. Each physician who enters into the social contract of caring for patients must contend with the system’s inadequacies. Each physician must have the requisite professionalism to identify how these external factors threaten their ability to deliver humane and competent medical care and act to address the deficiencies.

Communication skills are a major aspect of medical professionalism and how the public perceives physicians. Regrettably, only two-thirds of respondents in public polling expressed that “physicians have a good bedside manner,” with one-third dissatisfied with this essential humanistic skill. In contrast, the same study showed that 85% of the public believe that physicians have “good” or “excellent” “medical knowledge.”

One well-studied variable in professional development is the influence of the “hidden curriculum” embedded within medical learners’ environments.21 At the bedside, the requirement to follow institutional and provider team norms can lead ethical students and residents to engage in unprofessional behavior during medical training (e.g., falsifying medical records because of a shortage of time) that could be carried over into the physician’s career, ultimately resulting in disciplinary action.22 Another set of well-studied challenges to professionalism are potential conflicts of interest created by industry that can affect physician decision making.23

This transformative moment in U.S. health care requires the profession to assert the need for professionalism and to assess the ethical and humanistic foundation provided throughout the educational continuum of medicine. Professionalism begins in the premedical environment, spans across medical school, continues throughout residency and fellowship training, and extends through continuing medical education, thereby preparing, educating, and sustaining practice patterns necessary for decades of clinical practice devoted to the care of patients.

The Premedical Years

Three domains shape recent changes in premedical curricula: academic readiness, “preprofessional” readiness, and diversity—leading into a holistic review during the admissions process. The Medical College Admission Test has been revised to include not only the natural and life sciences but also core principles in the social and behavioral sciences, and critical analysis and reasoning skills.24 These welcome changes encourage premedical learners to appreciate exposure to philosophy, anthropology, sociology, and psychology as valuable preparation toward medical education, including the groundwork of critical thinking skill building.

Additionally, premedical students will be evaluated for “preprofessional” personal competencies by premed advisors, those writing letters of recommendation, and medical school admission committees. These competencies are based on knowledge, skills, and experiences from the social, ethical, and interpersonal domains that serve as a foundation for further maturation in the medical education process. The nine “preprofessional” competencies are service orientation, social and interpersonal skills, cultural competence, teamwork, integrity and ethics, reliability and dependability, resilience and adaptability, capacity for improvement, and oral communication.25

PRIME conference faculty concurred that this paradigm shift in the medical school admissions process requires screening that reviews applicants in a way that transcends factual knowledge testing. The experiences of the student, and the letters of recommendation that reflect these experiences and attributes, should become increasingly important. The emphasis should shift
from applicants who simply score best on knowledge-based tests to those who exemplify professionalism. In turn, medical ethics and humanities should be transformed from “elective” prerequisites for admission to essential components in the foundation necessary to become a physician. This background will better enable the physician to reflect on subtleties of the physician–patient relationship and to be prepared for the ethical dilemmas in medical practice. Ethics, literature, art, and history provide means to foster this reflective capacity.4,5

The Medical School Years
Matriculation into medical school marks a transition where the educational outcomes are assessed as students develop skills and acquire knowledge focusing on the patient. Rather than prescribing credit hours in required topics, the LCME is less prescriptive regarding requirements of content and expected outcomes. The number of hours devoted to particular subjects, space, faculty numbers, and instructional formats are not rigidly specified. Each medical school must ascertain how to best use its resources to deliver the requisite content based on its defined mission and educational program objectives. Content acquisition is assessed nationally by the United States Medical Licensing Examination and by internal assessments.

The LCME accreditation standards in place now state that “a medical education program must include behavioral and socioeconomic subjects…. [Including] medical humanities [and] medical ethics” and “must include instruction in medical ethics and human values and require its medical students to exhibit scrupulous ethical principles” (ED 10 and 23).26 To evaluate these topics, the LCME requests a basic listing of the number of sessions, a review of how student learning is assessed, and student evaluations of their education in these areas. Medical schools must also describe how breaches of ethical conduct are handled. Despite, or because of, these requisite overarching goals for ethics and humanities, about 1 in 11 students believe their course work is excessive in ethical decision making, and 1 in 6 believe their instruction in “professionalism” is excessive.27 This may be because students do not fully understand the relevance of the information in the context of patient care.

The necessary end point of “appropriate” content in ethics and humanities should be the students’ successful attainment of knowledge and skills that facilitate their formation as medical professionals. The AAMC Medical School Graduation Questionnaires allow the LCME to follow up on outliers (those where a significant number of students identify “inadequate” coverage of a topic). The evaluation of content coverage is qualitative, not quantitative, and each medical school must define how ethics and humanities contribute to their educational objectives and competencies in professionalism.

The consensus among PRIME faculty was that curricula in ethics and humanities geared toward fostering professionalism should be structured upon defined competencies and articulated outcomes that are linked to longitudinally integrated content and assessment. The LCME expects that educational program objectives should “be stated in outcome-based terms that allow assessment of student progress in developing the competencies that the profession and the public expect of a physician” (ED 1A).26

Meaningful inclusion of ethics and humanities in the curriculum may be more likely if these subjects have an “organizational home,” such as a department or center. In 2011, only 28 of 125 medical schools had ethics and/or humanities as a formal department or center or had an associate dean in ethics and/or humanities, according to a survey sent to all deans of the LCME-accredited medical schools (which had a 100% response rate).28 The explicit inclusion of ethics and humanities as foundational to medical education competencies clearly calls for the existence of a formal curriculum in ethics and humanities that ideally is integrated in, and throughout, the medical school curriculum. Its presence should be continuous, with elements throughout the preclinical and clinical experiences that build progressively toward students achieving the desired competencies. Challenges include defining terms, acknowledging current pedagogical organization, and linking teaching and assessment to comprehensive prespecified outcomes. Each school must define the content to be included under the category “medical humanities,” and link this content to the school’s competencies and mission. Governance of the curriculum and the relationship to the school’s power structure is of particular importance in considering the ability to include these subject areas, as medical ethics and humanities faculty may or may not participate in the curriculum governance process.

Many medical schools do not have properly trained faculty in ethics and humanities to ensure that proper expertise is available for pedagogy and in curricular planning related to professionalism, making the threats of the hidden curriculum more tangible. Educational programs in ethics and the humanities need to be taught by experts comparable to those faculty teaching more traditional disciplines, lest these important topics suffer not because of content but because of poor execution. Medical school faculty members need to be explicitly aware of how ethics and the humanities contribute to the objectives and competencies for physicians-in-training. Educators without such training may be higher in the power structure with conferred authority over professionalism education, but could be at a disadvantage in advocating for curricular content and time when compared with faculty members with this training or compared with trained educators in nonprofessionalism content areas. Ethics and humanities faculty members, regardless of background, need to ensure that their faculty peers and students understand their contributions to professionalism formation. Schools should endeavor to broaden faculty development and resources in these critical domains to ensure a sustainable and high-quality effort in ethics and medical humanities.

For medical ethics and humanities education to be salient in professionalism pedagogy, educators need to evaluate proactively how they contribute to professional outcomes. These outcomes may be qualitative or quantitative, but should be articulated by the school, and then evaluated for the success or failure of the teaching effort. Objectives of teaching must be directed toward instilling the desired values and behaviors into each student. The integration of medical ethics and humanities should be with “a distinct practical purpose in view”—the beneficial care of the patient.29 It is also important to acknowledge that the humanities do not lend themselves to the same quantitative
assessment of the physical sciences. Other, more relevant means of assessing outcomes are needed. The teaching should be based in clearly articulated goals, even if not toward quantitative outcomes.

The Residency Years

Residency training is associated with a change in the focus and outcomes of medical education. The ACGME aims for each learner to progress on a pathway from novice to mastery in the requisite knowledge, attitudes, skills, and behaviors to care for patients. Residency is also a period of professional development when lifetime habits of mind and practice are consolidated and thus is especially ripe for instruction in professionalism.

One of the outputs of discussions at the PRIME conference was that this model requires a proactive stand on assessment. The ACGME (and the National Board of Medical Specialties) strives for resident learners to master the content and behavior outlined in the general competencies. The ACGME’s warrant is grounded in the social contract to ensure that residency programs produce physicians who exhibit the values and virtues of professionalism. This warrant also aims to ensure the safety of medical encounters that are conducted with humanistic caring and self-effacement (also called altruism). Residency educators, then, must be advocates for our residents and our patients, while being excellent role models whom residents can emulate.

This effort is challenged by the realities of residency training, which may include a training environment in which problematic or even disruptive behavior is tolerated; the specific challenges encountered by trainees, such as stress and sleep deprivation; and insufficiencies related to faculty, such as training, commitment, numbers, support, and reward. For example, evidence indicates that even when faculty are supervising trainees’ interactions with patients, they don’t take advantage of the available opportunities to teach about ethics, humanities, and professionalism.

Finally, medical ethics and humanities educators must recognize that they are competing with others for precious time in the curriculum, in the context of a shrinking workweek due to duty hours restrictions. Securing and maintaining time with learners will require ongoing effort and vigilance.

The focus of ACGME accreditation has shifted recently, with emphases on educational innovation and improvement, improved attention to educational outcomes, greater efficiency in accreditation, and enhanced communication and collaboration with key internal and external stakeholders. The ACGME’s Next Accreditation System intends to shift the goals to outcomes-based learning, thereby giving programs latitude to design ways to meet these outcomes. This system allows good programs to innovate and continuously improve, while assisting improvement of poor programs.

This enhanced flexibility in accreditation allows for a more appropriate review of programs based on specific specialty needs, with a more meaningful and more manageable review of programs. Implicit in this accreditation change is the need for faculty development, including program directors and residency review committees, to engage residents in assessment of milestones. Overall, the burden of accreditation should be substantially reduced.

The ACGME is setting the stage for semiautonomous administration of resident maturation, giving each program the opportunity to transform its learning environment, along with each teacher and learner. In the competency of professionalism, residents must demonstrate the inculcation of virtues and ethical principles that will support provision of care consistent with the highest ethical and professional standards. Professionalism is a subset of all milestones that are evaluated in all of the competencies. Importantly, given recent lapses in some residency programs regarding testing fraud, the ACGME has a requisite expectation that professionalism be part of all resident and faculty member skill and behavior sets. These virtues and principles require educators to be engaged in meaningful ongoing relationships with trainees so that they can role model, observe, challenge, share, process, give feedback to, evaluate, and guide each resident on a moral journey of personal development.

It is important to note that the PRIME conference did not extend its efforts to the next opportunities for professionalism training in fellowship programs, and the continuity of professionalism in ongoing clinical care. The Academy for Professionalism in Health Care (APHC), founded at the PRIME conference, will examine the postresidency aspects of professionalism and work with relevant accreditation organizations (the ACGME and its review committees, and the Accreditation Council for Continuing Medical Education) to examine how medical ethics and humanities education can promote professionalism at these career stages.

Discussion

The PRIME conference emphasized that all educators, including those in medical ethics and humanities, are held accountable to the educational standards of the LCME and ACGME. Educators from each school and residency program must tailor their curricular goals and objectives toward meeting the ACGME’s general competencies, of which professionalism plays a pivotal and pervasive role. Faculty assets and institutional culture will constrain and circumscribe these goals and objectives. These factors necessitate that each program have substantial latitude to use varied approaches, methods, and outcomes for assessment. From this overarching message, two major areas of focus resulted from the PRIME conference.

First, medical ethics and humanities education is essential to the formation of professionalism by enhancing ethical reflection and critical thinking skills. Moral introspection and analytic skills enhance discernment of the morally problematic aspects of health care and reinforce the altruistic foundation of medicine. These efforts should result in developing physician activism to address our health care system’s flaws as well as to recognize the challenges to their own professional selves. The critical nature of developing introspection within each physician is underscored by recent evidence from Tilbur and colleagues: Of more than 2,500 physicians surveyed about “who bears major responsibility for health care costs,” a majority of physicians chose trial lawyers, hospitals, insurance companies, and patients—more than they chose physicians themselves. These attitudes emphasize how ethics and social justice require physicians to consider whether they can abrogate their responsibility for the system.

Enhanced professionalism education may facilitate learners’ recognition of
health care injustice and the perils of self-interest, aiding in their combating quiescence of health inequity and having them reject nonaltruistic motives. Future professionalism pedagogical research should demonstrate how medical learners use their moral reflection skills to overcome injustice and unprofessional behavior and promote the ideals of just care, cultural competence, and diversity. These educational efforts should demonstrate that the values of altruism, fairness, and tolerance endure through the challenges of the hidden curriculum—such that our professional physicians can thereby better serve society as change agents.

Ethics and humanities education has obvious ties to the LCME and ACGME competencies generally, and to professionalism specifically. Including ethics and humanities in accreditation encourages accountability of the specific area of knowledge, attitudes, skills, and behaviors in professionalism formation. Medical learners benefit through the actualization of professionalism in the physician–patient relationship. LCME and ACGME goals not only tolerate diversity of methodology but also encourage and promote it. Diversity of pedagogy ranges from traditional in-person didactic, small-group, work rounds, and one-on-one interactions and role modeling, to electronic aspects of education using Web streaming, podcasting, and videoconferencing. The PRIME conference emphasized that an open approach to pedagogy and an open-source approach to storing and sharing medical education materials would benefit all programs. In this regard, PRIME and the APHC entered into a strategic alliance with the AAMC MedEdPORTAL program (MedEdPORTAL.org) to help build a database of educational material in professionalism, ethics, and humanities that is peer reviewed, cross-linked, and an open source for collaboration. APHC members are actively engaged in ongoing program development in medical ethics and humanities education to foster professionalism leading to the formation of physicians who can think and practice creatively and humanely.

Second, educational efforts toward professionalism require critical appraisal of previous efforts, assessing omissions, errors, and flawed framing. Some ethics and humanities educators may fear “standardized” content, thereby ossifying the evolution of a diverse curriculum. PRIME conference attendees agreed that such rigidity would be inappropriate and advocated instead for diverse perspectives and approaches. Lockstep, concrete pedagogy would stymie innovation and be antithetical to scholarship and academic freedom. Such rigidity would also fail to meet site-specific contexts and standards regarding professionalism. Standardization contradicts the stand of the PRIME faculty and the accreditation organizations on how medical education can best evolve. We prefer accountability, which can best be achieved when educators have a palette of goals, objectives, methods, and assessment means drawn from many disciplines and programs, so that all programs can decide what to do with the resources they have for the culture they wish to promote. Taking a “core content” approach with wide variation in delivery allows for evolution of medical education while also maintaining those aspects of professionalism most salient to future physicians.

Some Challenges

The largest challenge for some educators may be moving beyond the intrinsic value of the educational content to the requisite setting of goals, objectives, and evaluation. Outcomes-based education requires translation from disciplinary grounding to assessable impact (directly or indirectly) on patient care. Professionalism allows us to care for patients in ways that actualize our knowledge of medical ethics and humanities beyond a theoretical construct.

We assert that ethics and humanities have a special role to play in helping trainees to become medical professionals and in sustaining the professionalism of practicing physicians. In this context, ethics and humanities are instrumental—and there is a requisite need to determine whether the intended impact has been made on the learner. Educational evaluation of ethics and humanities is something we can no longer ignore. Doing so imperils the impact of educational reform and risks complete political marginalization within medical schools and training programs.

Concluding Remarks

The prior two PRIME workshops (in 2010 and 2011) and the 2012 PRIME national conference concluded that ethics and humanities are a fundamental component for the development of professionalism in the medical learner. The development of professionalism is based on the knowledge, attitudes, skills (including critical thinking skills), and behaviors that are acquired from a foundation in medical ethics and humanities education. Educators involved in the broad spectrum of medical ethics and humanities education must work together to create a vision of their essential role in the development of the medical professional. It is agreed that medical ethics and humanities educators need to reject notions of reductionism that some fear might accompany educational evaluation. At the same time, educators must embrace imaginative, diverse thinking on how ethics and humanities can and should contribute to medical education toward professionalism. This will be essential if our learners are to become the medical professionals that patients and society deserve. Structural changes in medicine mean that educators cannot take for granted that professionalism will survive reform. Ultimately, educators will be held accountable for trainees’ attainment of the ACGME’s general competencies, including professionalism.

Acknowledgments: The authors acknowledge the helpful assistance of Amerisa Waters, Andrea Sinclair, and Cori Ast for their efforts in this project.

Funding/Support: The Project to Rebalance and Integrate Medical Education was supported by the Patrick and Edna Romanell Fund for Bioethics and Pedagogy of the University at Buffalo.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

Disclaimer: The following authors have leadership roles in the following organizations: Dr. Doukas, the Academy for Professionalism in Health Care (APHC); Dr. Kirch, the Association of American Medical Colleges; Dr. Brigham, the Accreditation Council for Graduate Medical Education; Dr. Barzansky, the Liaison Committee on Medical Education; Dr. Carrese, APHC; and Dr. Fins, the American Society for Bioethics and Humanities. The views expressed by the authors reflect their personal perspectives and do not necessarily reflect those of their respective organizations. Dr. Wear is the representative of the Patrick and Edna Romanell Fund for Bioethics Pedagogy of the University at Buffalo.

Previous presentations: The materials in this article are based on presentations at the Project to Rebalance and Integrate Medical Education (PRIME) National Conference on Medical Ethics and Humanities in Medical Education, May 10–11, 2012, Louisville, Kentucky. PRIME presentation slides and videos are freely available.
References


28. 2011–2012 Liaison Committee on Medical Education Annual Medical School Questionnaire, Part II. Liaison Committee on Medical Education Archives. [Available on request from the authors.]


