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ARTICLE

# MEDICAL PROFESSIONALISM AND THE FORMATION OF RESIDENTS: A JOURNEY TOWARD AUTHENTICITY

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Let me begin by thanking the Holloran Center and the Law Journal of the University of St. Thomas School of Law for the opportunity to share my thoughts and observations about medical professionalism—in particular, medical professionalism as it pertains to the formation of resident physicians. Medicine, unlike most professions, requires a period of formal, supervised training after graduation. These educational programs, called residencies, are accredited by my organization, the Accreditation Council for Graduate Medical Education (ACGME).[1] There are 8,186 residency programs in the country, which in the aggregate house 103,367 residents in 122 specialties and subspecialties.[2] I will use residents and residencies to illustrate both the problems and opportunities associated with our topic: the formation of an ethical professional identity. The questions of professionalism and the formation of young professionals can thus be stated: How do we preserve and nurture authentic human and moral reflexes in our young learners? How do we foster authentic professionalism and moral development in young people when the context in which young people are being formed is itself morally challenged?

This article is organized into three sections: first, background information about residents and residencies; second, examples, both egregious and normal, of challenges to resident formation; and, finally, proposed solutions to address these challenges.

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* Former Executive Director and CEO of the Accreditation Council for Graduate Medical Education.

1. Accreditation Council for Graduate Medical Education, http://www.acgme.org (last visited May 7, 2008).

2. *2005–2006 Annual Report*, 2006 ACCRED. COUNC. GRAD. MED. EDU. 8–9, *available at* http://www.acgme.org/acWebsite/annRep/an_2005-06AnnRep.pdf.

## I. Background

As any of the nation's 106,000 medical residents could attest, residency is an intense experience with a learning curve steeper than any other area of physician formation. The differences in knowledge and skill between first-year and chief residents are profound. The residents' journey is one in which they learn the practical skills of medicine. Residents discover clinical wisdom, yet they also discover themselves. They are seeking to become authentic physicians. It is a journey that is surrounded by external drama, but actually proceeds from the inside. It is a journey that calls not only on their intellect, but also on their will and their imagination. Residents learn to discern, tell the truth and make good clinical judgments in very complex, clinical situations.

Because of the intensity and importance of this most formative phase in physician development, and because the habits of a lifetime are developed during this period, we (the staff and volunteers of the ACGME) pay attention not only to the residents' progress, but also to the context in which residency occurs. The learning environment is crucial and is monitored by ACGME's Institutional Review Committee.[3] Residents and residency programs offer a particular view of the formation of an ethical professional identity.

## II. Some Challenges to the Formation of Young Professionals

One of my mentors, Parker Palmer, a sociologist in Madison, Wisconsin has said:

> Hope is not the same as optimism. An optimist ignores the facts in order to come to a comforting conclusion, but a hopeful person faces the facts without blinking—and then looks behind them for potentials that have yet to emerge—knowing that the human experiment would never have advanced were it not for the possibilities, however slim, that lie hidden behind the facts.[4]

Using Palmer's definition I can say that I am cautiously hopeful, but definitely concerned, about the formation of medical professionals in the modern world.

In May 2002, Palmer facilitated a retreat for residency program directors who had received the ACGME's Parker Palmer Courage to Teach Award. During the retreat, a case was presented about a liver transplant donor who had died while in intensive care. He died despite the fact that the surgery had gone smoothly and despite the fact that his wife, who was with

3. For a description of ACGME Institutional Requirements, see *ACGME Institutional Requirements*, 2007 Accred. Counc. Grad. Med. Edu. 1–17, *available at* http://www.acgme.org/acWebsite/irc/irc_IRCpr07012007.pdf.

4. Parker Palmer, Address at the Marvin Dunn Memorial Lecture at the ACGME Educational Conference: The New Professional—Educating for Transformation (Mar. 4, 2006).

him throughout the entire post-surgical period, insisted repeatedly and to no avail that her husband was going downhill fast. Three months later, the State Health Commissioner issued an incident report saying: "The hospital allowed this patient to undergo a major, high-risk procedure and then left his postoperative care in the hands of an overburdened, mostly junior staff, without appropriate supervision."[5] On the day the donor died, a first-year surgical resident with twelve days of experience in the transplant unit had been left alone to care for thirty-four patients. She could not—and did not—monitor every patient with the care and precision required.

I present this case as an example, perhaps an extreme example, of abandonment not only of the patient, but also of a very junior resident. I also present it because of the response it evoked from a set of doctors analyzing it. The doctors at the "Courage to Teach" retreat discussed the case in small groups and almost universally came to the conclusion that system issues were to blame. The analysis was impersonal and abstract. Culpable parties were the hospital leadership, the clinical department chair and the system of supervision, inexperience and staffing.

During the debriefing, Palmer asked a question that brought the group into deep silence: "Who is the moral agent of this story?" We were not used to thinking in terms of moral agency. The group agonized over the question and the fact that, by habit, we had avoided asking the question. Palmer then inquired: "What if residents were expected to be the moral agents of the institutions in which they work and learn?" He suggested that young learners, not yet acculturated by prevailing institutional mores, offered a more pure look at the moral issues in healthcare than those of us who, by experience and habit, had developed a ready list of explanations to cope with such failings.

This case invites exploration of several themes about the development of professionalism and value systems in modern healthcare systems. Although it is tempting to highlight the several external forces that influence the developing professional today, I speak more to the developing professional's internal influences. To frame this discussion, I think of medical professionalism as more potato than lettuce; lettuce rots from the outside in while a potato rots from the inside out. For example, there has been much talk about the influence of commercial support of education—I put that into the lettuce category. It should not happen. Fixing it might involve removing some of the outer leaves of lettuce that appear brown and slimy. For me, and for many who take residency education seriously, the question of professionalism is deeper and emerges from the internal: How do we preserve and nurture authentic, human and moral reflexes in our young learners?

5. N.Y. State Dep't of Health, *State Health Department Cites Mt. Sinai Medical Center for Deficient Care in Living Liver Donor Death*, DOH NEWS (Mar. 12, 2002), *available at* http://www.health.state.ny.us/press/releases/2002/mtsinai.htm.

How do we foster authentic professionalism and moral development in young people when the context in which young people are being formed is itself challenged morally?

### *A. A Few Words about Language*

ACGME has identified professionalism as one of six general competencies used in the accreditation of residency programs. ACGME requirements for professionalism include:

> Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:
>
> Compassion, integrity and respect for others; responsiveness to patient needs that supersedes self-interest; respect for patient privacy and autonomy; accountability to patients, society and the profession; and, a commitment to excellence and ongoing professional development.
>
> . . . Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.[6]

As this definition makes clear, medical professionalism depends heavily on the quality of a physician's inner life. Transcendence of self-interest is not a technique—it is a way of being. The resident, in addition to learning the science and art of medicine, must also learn a new way of being in the world in order to become a fully-developed professional. The resident's journey is an inner journey. We have a heavy obligation to help them.

### *B. Some External Variables that Influence Developing Professionals*

Although the journey is deeply personal and the inner journey is heavily influenced by context, both institutional and societal contexts influence the development of professionalism. Is it possible to model and teach professionalism in institutions that do not demonstrate professional values? Is it possible to teach and model professionalism in a society that does not demonstrate social justice, that accepts limited access to health care for the uninsured, and that tolerates demonstrably worse healthcare outcomes for the poor?

No, the current context in which resident formation occurs does not make the task of fostering medical professionalism easy. Relentless pressures of time and economics, fragmentation of care and the relationships

6. ACGME Board, *Common Program Requirements: General Competencies*, 2007 ACCRED. COUNC. GRAD. MED. EDU., *available at* http://www.acgme.org/outcome/comp/GeneralCompetenciesStandards21307.pdf [hereinafter *Common Program Requirements: General Competencies*].

supporting care, increasing external regulation, exciting but disruptive new knowledge and technologies and, above all, the broken systems of health care dominate conversations and characterize the external environmental context.

### *C. The Internal Context of Healthcare*

In addition to external pressures, healthcare delivery systems demonstrate their own internal values by their behavior. The news in this field is not promising. The internal context of the system of care is daunting. We lie regularly. Justifiable lack of trust pervades the system. Beth McGlynn[7] estimates that only fifty-four percent of patients receive care that is known to be the best, a number that falls to two or three percent when evidence-based guidelines are bundled.[8] Hospital websites proudly announce that the hospitals they promote provide the best care with the best doctors, the best technology, etc. Some are so detached from acknowledging human suffering that they make it seem as though a hospital might be a fun place to visit. As a profession we have tolerated that message, forgetting Hannah Arendt's adage that every time we make a promise we should plan for the forgiveness we will need when that promise is broken.[9]

The hospital bill offers another example of a breach in professionalism. It is frequently not interpretable, even by the hospital's own administrative staff—let alone patients and their families. Paul O'Neill[10] has said that he knows of no other industry that regularly accepts a thirty-eight percent reimbursement on amounts billed, a percentage he states is the national average. We all know how the number is derived. Hospitals actively negotiate with several insurers in ways designed to cover costs. Inflated bills and discounted deals result. This system, while cumbersome, works fine from the hospital's perspective, as long as the aggregate reimbursements cover expenses and some margin. The system works fine, that is, until a patient shows up with no insurance and with no one to negotiate for a discounted rate. Further, the undiscounted fees are billed to those least able to pay. The hospital bill is about as far away from " compassion, integrity and respect for others; responsiveness to patient needs that supersedes self-interest; . . . accountability to patients" as one can get.[11]

It is hard to foster professionalism when incongruities between espoused and evident behaviors are so apparent. I call this the "Abraham Verghesse problem." At a spectacular forum sponsored by the American

7. Beth McGlynn, Associate Director of Rand Health, Rand Corporation, Address at the AMBS Symposium: The Quality of Healthcare in the United States (Sept. 2005).

8. *Id.*

9. HANNAH ARENDT, THE PORTABLE HANNAH ARENDT 180–81 (Peter Baehr ed., 2000).

10. Letter from Paul O'Neill, former United States Secretary of the Treasury, to Author (Mar. 2004) (on file with author).

11. *Common Program Requirements: General Competencies*, *supra* note 6.

Board of Internal Medicine in the summer of 2005, the audience was, with some justifiable pride, celebrating the accomplishments of the Physician Charter on Medical Professionalism.[12] This well-written document, endorsed by many, clarifies principles and commitments in a very important way. Yet, in the midst of the celebratory speeches, Abraham Verghesse stood up and said that his medical students shrugged that the principles espoused in the Charter were self-evident—it was why they went into medicine. Why were so many making a fuss about it? Dr. Verghesse then said: "Perhaps we pay so much attention to the words because there is no other evidence that the phenomenon exists." Everyone became silent.

## III. Potential Solutions

In spite of these examples, I remain cautiously hopeful, using Parker Palmer's definition, because there are also a number of vectors in play that serve to support the good moral development of young professionals—vectors that can offer some hope for solutions.

There is a deep hunger for a return to classic professional values. Many good people are seeking clarity about how best to do that in the modern world. As Parker stated, "[in] looking for potentials that have yet to emerge . . . [and] at the possibilities hidden behind the facts . . . ,"[13] we can find allies that can help move this particular human enterprise forward.

Dee Hock has said, "[s]ubstance is enduring; form is ephemeral. Preserve substance; modify form; know the difference."[14] The task before us is to be faithful stewards of the moral foundations of medical professionalism while adapting to the new and emerging forms of medical practice. By aligning the solutions to professional development with the fundamental faculties of human nature, we are connecting with values in medicine—truth-telling, altruism and practical wisdom— that go back several millennia and give us a solid foundation on which to stand. If in fact medical professionalism is like a potato, and not just lettuce, our responses to the new forms of medical practice will either reveal deeper lesions of professional values or opportunities to drag the goodness of medicine into the modern world.

How can we best proceed? I think it is best to work with, rather than against, human nature. What does that mean? Residents, their teachers, and all humans come equipped with three faculties that are naturally aligned with the goals of professionalism: intellect, will and imagination.[15] The ob-

12. To view the Charter on Medical Professionalism, see Linda Blank, *Medical Professionalism in the New Millennium: A Physician Charter*, 136 Annals of Internal Med. 243–46 (2002), *available at* http://www.annals.org/cgi/content/full/136/3/243.

13. Palmer, *supra* note 4.

14. Dee Hock, Birth of the Chaordic Age 198 (1999).

15. Jacques Maritain, An Introduction to Philosophy 112–13 (E.I. Watkin trans., 2005).

ject of the intellect is truth, that of the will goodness, and that of the imagination beauty. The job of a good doctor boils down to discerning and telling the truth, putting what is good for the patient before what is good for the doctor, and making clinical judgments that harmonize—harmonize in ways that are creative and sometime even beautiful—the particular needs of a patient with the general scientific evidence at hand. This construct invites a new frame (or rather a very old frame) for organizing experiences: How good a job did I do in discerning and telling the truth, in putting the patient's interest first, and in accommodating the particular realities of the patient's situation in my clinical judgments?

### *A. Some Examples of Truth-Telling in Healthcare*

Some hospital websites are beginning to tell the truth about their clinical outcomes. The Dartmouth-Hitchcock website, for example, provides a list of several clinical procedures and diseases as well as Dartmouth's performance for each.[16] Three columns then compare Dartmouth's performance with the national average and national best performance. While still unavailable for most hospitals, Dartmouth is not alone in its transparency; others are beginning to follow. The Cystic Fibrosis Foundation website, for example, provides comparative outcome data for each of the major cystic fibrosis treatment centers in the country.[17] While not yet available for other diseases, the data inevitably will be compared. As a profession, we are beginning to tell the truth.

We are also beginning to tell the truth about medical error. Many hospitals now have formal programs in which patients are told exactly what happened, given an apology, and provided with some evidence that the hospital staff is working to reduce the probability of that error occurring again.

### *B. Attention to the Inner Life of the Physician*

We must acknowledge that we, the teachers of medicine, must attend to our own inner landscape. Teachers who take resident formation seriously find that both resident and teacher are changed. The journey to authenticity is not being taken by the resident and faculty alone—the profession of medicine is on the same journey. For that matter, our American society is on a journey to authenticity as well. To the extent that our profession discerns and tells the truth about healthcare, to the extent that it puts what is good for the patient and the public before what is good for the doctor, and to the extent that it is creative and generative—it is an authentic profession. Authenticity in this sense is a verb, not a noun. It is not a state of rest; it

16. *See* Dartmouth-Hitchcock Medical Center, Overall DHMC Performance Results, http://www.dhmc.org/qualityreports/list.cfm?metrics=Overall (last visited May 7, 2008).

17. Cystic Fibrosis Foundation, Care Center Data, http://www.cff.org/LivingWithCF/CareCenterNetwork/CareCenterData/ (last visited May 7, 2008).

requires constant vigilance. Residencies and the institutions that house them should be built on the bedrock of the intellect, will and imagination, and they should offer experiences that strengthen and test these capacities.

### *C. Some Practical Steps*

We must debunk the myth that our institutions are external to ourselves. We tend to accuse others of our own sins; we tend to blame the nebulous "they" for violations of standards that we, alone and together, must defend. Palmer has stated:

> [P]rofessionals, who by any standard are among the most powerful people on the planet, have the bad habit of telling victim stories to excuse behavior: "The devil (boss, rules, pressure) made me do it . . . ." The extent to which institutions control our lives depends on our own inner calculus about what we value most. These institutions are neither external to us nor constraining, neither separate from us nor alien. In fact, institutions are us. The shadows that institutions cast over our ethical lives are external manifestations of our own inner shadows, individual and collective. If institutions are rigid, it is because we fear change . . . . If institutions are heedless of human need, it is because something in us is heedless as well.[18]

In our journey to authenticity as a profession, we must call institutions to account as we call ourselves to account. We may pay a price; we may be marginalized, demoted or even dismissed. Yet, the price we pay for continuing to pretend that we are helpless victims, for living professional lives in conflict with our deepest values, is greater. We must resist unprofessional institutional behavior—not because we hate our institutions, but because we love them too much to allow them to fall to their most degraded state.

Perhaps we should take seriously Palmer's suggestion that we create a system in which residents and other early learners could function as moral agents. Like the canary in the coal mine, the residents could detect and warn others when institutional conditions (relationships) are toxic to professional values. They could keep us honest about how we are dealing with the sick. This approach would require that we both listen to and validate the residents' feelings and that we train them to use the human heart as a source of information. This, of course, is problematic.

Embedded in the higher education process is a systematic discounting of the subjective; it is thought to be a source of bias and unreliability. Yet, good physicians do more than simply pay attention to objective details. Compassion, empathy, and deep respect are all dependent on truths revealed by the human heart. Perhaps the heart, like the mind, can be taught to discern truths. Perhaps when the heart is uneasy we should listen more

18. Palmer, *supra* note 4.

carefully and mine the information it is giving us. Perhaps a disciplined approach could enable moral agency to develop.

Lacking a disciplined approach, we too frequently socialize residents to cope with, rather than master, the systems in which they work and learn. They live in the cracks of a broken system, but they are the glue that often holds it together as they get things done. However, residents are renters and not owners. They can identify system issues but do not feel empowered to fix them. Coping with systems in which patient safety depends on individual vigilance rather than design is wearing and dangerous, and we will fail every hundred or thousand times—well below what we know is achievable in other sectors of our society today. It also inhibits the formation of true professionalism. The solution requires attention to group as well as individual formation.

We have assumed that professionalism is an attribute of individuals alone. It is not; it also marks communities. The assumption that the doctor-patient relationship is a one-to-one relationship is flawed. In fact, it is more like a twenty-to-one relationship—with several different types of doctors, nurses and other health care professionals interacting with the patient and each other in ways that are variable and frequently disorganized. Needed is clarity for all about the roles, authorities and functions of the various members of the team. Cultivating communities to discern and tell the truth to each other, to enable and facilitate altruism, to make good promises and to seek forgiveness, and to harmoniously integrate true hospitality into care plans depends on paying attention to small group as well as individual formation. It will help us respond to society's call for respect.

Lastly, we must not stand passively by when our country violates fundamental principles of social justice. Every resident physician encounters the poor. Many academic health centers include care of the poor as part of their mission and are frequently the backbone of such care for their communities. Yet, widespread disparity exists across the larger society and even within academic centers. The profession has been ineffective at best, and silent at worst, about healthcare disparity. We would be well-served to have a bias toward rather than against the poor—the larger society judges us over time by our response to its needs.

### *D. Postmodernism: Can Medicine Offer a Corrective?*

We live in a society in which truth is viewed as nothing more than a social construct. Spin doctors, rather than real doctors, prevail. They can construct a view of social justice that will serve their master. Medicine, in its very nature, functions under a different set of assumptions. Rather than a postmodern, socially constructed view of truth, doctors deal with things like gallstones and brain tumors. Medicine accepts that there is a truth and that it can be known, although sometimes with great difficulty. A gallstone is not

a social construct. A doctor may or may not detect it, but ultimately truth trumps opinion. If we by habit discern and tell the truth, we can offer the larger society an approach to truth that conforms to reality, rather than mere social constructs that attempt to create reality.

Good doctors are humble; even the arrogant ones encounter failure. Postmodernists lack that corrective and can become quite proud, marked by hubris and convinced that they are right. Flannery O'Connor has said, "[i]n the absence of the absolute the relative becomes absolute."[19] This is the source of all fundamentalism: religious, political or other.

We cannot accept socially constructed views of social justice. This is not an issue of conservative or liberal—it is deeper than that. We are called upon to provide health care for all of our citizens; it is their due. In a society with resources and know-how, failure to care for the sick is a breach of professionalism. Further, we must respond to the needs of all of our citizens in ways that offer an example for our young learners. They, too, will judge our words and actions and grade us on professionalism. When idealistic young people are told to adjust their values downward in order to accommodate our accommodation, we have a problem. If we get this right, the "crisis" in professionalism will fade, and we will have achieved the next step on our own journey towards authenticity. We can deal with external threats once our internal values are sound and our courage is found.

19. FLANNERY O'CONNOR, THE HABIT OF BEING 477 (Sally Fitzgerald ed., 1979).