High Road, Low Road: Professionalism, Trust, and Medical Education

Professionalism in medicine both encompasses the ideals we aspire to and defines the corner we recognize as incompatible with those ideals. High road and low road: academic medicine is concerned with both. Academic medicine seeks to promote social good through excellence in science, clinical care, education, and community engagement. And, at the same time, academic medicine has the responsibility to protect the public by admitting and preparing competent and ethical members of the profession. Similarly, medical education itself should exhibit the aspirational ideals of the profession in its underlying values and their translation to everyday life. A corollary is that medical educators have the duty to discern and intervene when those entering the field of medicine may have difficulty fulfilling their professional obligations in training and in future practice.

Three reviews in this issue of Academic Medicine examine our efforts to date in teaching professionalism in medical education.1-3 In their systematic review of articles published over nearly 4 decades, Berger et al1 found that curricula focusing on professional values and well-being strengthen learners' knowledge, self-reported attitudes and behaviors, and observed behaviors in educational settings. Frangos and Crampton2 evaluated 7 decades of published studies and similarly found that educational interventions to teach clinical empathy are effective, especially among some subsets of learners. Manca et al3 examined articles depicting intentional efforts to foster critical consciousness among medical trainees, finding that the curricula centered on 4 themes of fostering awareness of social, cultural, political, and educational dynamics. The authors reject notions of superficial outcomes of medical education in favor of learners' deepened ability to observe and critique and to self-observe and self-critique. Taken together, these reviews highlight challenges such as the paucity of reports focused on meaningful "real-life" results (e.g., better patient care or health outcomes); the problem of response and reporting biases; and the need for more rigorous, longitudinal, and substantive interventions. Nevertheless, the authors suggest that efforts to nurture professional ideals, practices, and capacities in medical education may indeed have some merit.

That said, other articles4-6 in the collection provide insights regarding aspects of the learning environment that may undermine, contradict, or negate the lessons of professionalism in medicine. Ludmerer4 affirms academic rigor, service to patients, demonstrations of altruism, and, ultimately, visionary leadership to restore medicine to a place of moral authority and policy influence in society. Concerned about inadequate resources and misaligned incentives in health systems, Ludmerer laments:

At the moment, medical education is being conducted in clinical environments that often encourage doctors to see as many patients as possible as quickly as possible without providing the time, caring, thought, and attention to detail that many patients need. Thus, the clinical learning environment often does not validate the principles that medical educators are trying to impart. This discord is the greatest existential threat to medical education and practice of the present.

Marcotte et al5 comment similarly on the failure of medicine to deliver on the promise of high-value patient care due to nonalignment with "bedrock" professionalism principles and overreliance on transactional and flawed approaches that fail to enable appropriate care standards and practices.

Trustworthiness of medical education institutions is a focus of McCullough et al,6 who describe the potential negative influence of organizational culture on learners.

Organizational culture includes the mission and values of an academic institution, what it expects and discourages, and what it tolerates—especially what it tolerates that should not be tolerated. For example, … an alienating organizational culture in which faculty come to think of themselves as factory workers and not professionals. The pedagogical result is to tolerate what should never be tolerated: putting before learners role models of merely transactional and not professional virtues, behaviors, and identity.

Medical students are caught "betwixt and between," argue Hafferty et al in their Invited Commentary, as such mixed messages proliferate and "organizational statements of mission seem at odds with educational practices." The learning environment has become subverted—hijacked and commodified, the authors argue—by outside pressures such as the "test prep industry," externally administered high-stakes examinations, and "market logic." By losing governance in the learning environment, the social institutions of medical education now have a problem of trust, the authors suggest, and one consequence is that the idea of professionalism itself is viewed negatively ("the ‘p’ word") by medical learners as repressive and weaponized.

Such concerns resonate with the reflections of Frye et al,8 who posit that professionalism education is overly simplistic and insufficient to address the issue of racism in medicine and society at large. Moreover, they argue that professionalism, as implemented in education settings, can serve as a "tool for social control" and cause real, if unintended, harm. The authors state that currently held professionalism expectations require honest critique, confrontation, and action, noting that "white norms act as the referent" and thus, for example, "dress or appearance associated with nonwhite social groups, like wearing natural hair, have been the subject of micro- and macroaggression, including disciplinary actions." Frye et al invite us to examine our values and their expression and ask that we, together, bring about change in the culture.
Dear Reader, we must be willing to engage in questions of true significance to medicine and medical education. These questions, as illustrated in this collection, are very hard. They can be unsettling or controversial, and they may be propelled by fast and fast-moving changes in society that feel well beyond our reach. Nevertheless, such circumstances are when leadership is most consequential and most welcome. We must endeavor in our efforts to earn each day the intellectual and moral trust of those we serve. And we must collaborate with many stakeholders, including most especially our learners and colleagues, to ensure that medical education is consonant with the imperatives of the future.

Stories appear in the media of misconduct by prominent leaders in higher education and academic medicine, national scientific laboratories, and clinicians entrusted with the care of students and student athletes on university campuses. Whether it is the omission of necessary disclosures or, worse, the engagement in a relentless sequence of egregious, exploitative, and predatory behaviors, professionalism failures are contributing to societal mistrust of medicine and science.

Lapses in professionalism are at the center of an exceptional study in this collection by Krupat et al of graduates of 2 medical schools. The authors found that those physicians identified as having professionalism issues while they were medical students were more likely to have problems later on in residency training (e.g., poor evaluations) and in clinical practice (e.g., malpractice claims). The authors also found a relationship between academic performance, professionalism, and subsequent problems, a connection that deserves further study. The results of Krupat et al’s study fit with those in the older literature on the pattern of repetitive misconduct by some physicians who are disciplined by state medical boards and also with findings in a recent report by DuBois et al documenting characteristics and antecedent behaviors of physicians who have been convicted of sexual exploitation of patients—a very low road, indeed.

This editorial was written prior to the COVID-19 pandemic. The extraordinary dedication, courage, and heroism of members of the health professions, along with essential workers, across the world have been illustrated each harrowing day. Clearly, the high road of professionalism is a crowded one. This experience has also shown that scientific evidence and discovery are truly critical in our efforts to protect and promote the health of the public.

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Editor’s Note: The opinions expressed in this editorial do not necessarily reflect the opinions of the AAMC or its members.

References