

Professionalism and the Teaching of Clinical Medicine:

Perspectives of Teachers and Students

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Abstract

Principles of medical professionalism include humanistic values, altruism, ethical and moral behavior, and a lifelong commitment to scholarship and learning. These principles can provide behavioral guidelines to residents, fellows and their teacher-physicians during the formative years of postgraduate training. This short paper presents some of the challenging professional questions raised during these years of training, where medical professionalism may help to guide us.

Key Words: Professional competence, physician's role, medical education, physician-patient relations.

AS A PRACTICING academic pulmonary intensivist for the past fifteen years, I have taught clinical medicine to hundreds of residents and fellows at the bedsides of critically ill patients in intensive care units. It is during the residency and fellowship years that “book-smart” medical school graduates mature into fully developed, autonomous physicians. Although they have all graduated medical school and they are all called “doctor,” it is not until they take on the role and responsibilities of doctoring that they truly become physicians. Tremendous change and growth occur during these years as a direct result of their hands-on care of a great many patients, under the supervision of experienced teacher-physicians.

High-quality clinical medicine and its teaching require consistent guidelines on how to behave as a physician and a clear vision of what one is trying to accomplish — in addition

to the knowledge, skills and tools of science and medicine. In other words, we need a road map and a destination, for “If we don’t know where we are going, then it doesn’t really matter which road we take” (to paraphrase the Cheshire Cat from *Alice in Wonderland*) (1). For these behavioral guidelines, we look to the essential principles of medical professionalism, such as humanistic values, altruism, ethical and moral behavior, and a lifelong commitment to scholarship and learning (2, 3).

The way we clinician-teachers conduct our own lives has a lasting effect on our trainees, since they look to us and how we behave for lessons on how to actually be a doctor. During these formative years, trainees and teachers develop strong bonds that often span entire careers. An essential part of the teaching of clinical medicine is role modeling — with trainees learning by example how to interact with patients, how to function as physicians and how to comport themselves as physicians on a day-to-day basis (4). And, as you might expect, they ask us many questions, both explicitly and implicitly. How do we ethically justify the “high-wire act” of allowing inexperienced students to practice on the vulnerable sick, knowing that mistakes might occur? The protection of our patients from harm must always be kept in mind. How do we simultaneously allow auton-

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omy and yet retain supervision — recognizing that doctors cannot learn to be decisive and accountable without the freedom to make decisions, to sometimes be wrong, and to learn from mistakes? Physicians must make scores of decisions daily, both large and small. I believe it is absolutely vital that my students develop the ability to make decisions, and to fully accept responsibility for the results of the decisions they have made.

How do physicians relate to each other and to society as a whole? What is our responsibility to the larger world? How do we balance practicing selflessly and making a living? What powers does our society invest us with, and what are the responsibilities that go along with these powers? What is the historical role of physicians in our society, how has that changed, and where is it going? These are all difficult, challenging questions, with continuously evolving answers.

Recent pressures on academic clinical-teachers have challenged our own abilities to best represent medical professionalism. Foremost is the conflict between medicine as a business and medicine as a profession (5). Academic medicine is in turmoil as a result of changes in health care reimbursement. The managed care industry does not include the costs of postgraduate training of physicians as part of their responsibility and, therefore, refuses to pay for it. Government-mandated patient-record documentation requirements for medical school faculty have become progressively onerous, leading to more writing on charts and less supervising and teaching. Fiscal pressures have forced clinicians to see increased numbers of patients in order to maintain solvency, thereby eroding the time available for the thoughtful education of trainees. Time for precious contemplative thought, study and research has dwindled.

A second area of conflict is the relationship between academic medicine and the pharmaceutical industry (6). We try hard to teach trainees to be independent of industrial pressures and in-

volvements which may influence their treatment choices. At the same time, industry is a major source of research funding for faculty at medical schools. Juggling these two often-conflicting agendas can be quite challenging.

A third area of tension is in one of the important underpinnings of medical professionalism, the self-policing of our profession — the willingness to admit errors and to report the errors of others. There is enormous conflict between doing this (because it is the right thing to do) and not doing this, for fear of repercussions — both internally from peers, supervisors and program directors, and externally from the malpractice industry and the justifiable fears of being named in the National Data Bank. These are just some of the major problems which test us and test our abilities to represent our profession to our students as we would like to.

American medicine in general and academic medicine in particular are constantly changing, driven by endless experiments in health care financing, new medical discoveries, and evolving societal needs and desires. We cannot plan for the future, since neither we nor our students know what the future will bring. Our responsibility, therefore, as clinical-educators and role models, is to prepare our students for this unforeseen future by providing them with a strong foundation, flexibility and clear sense of purpose. We hope to teach residents and fellows not only “to do things right” but also “to do the right things.”

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