Reflections on State Medical Board Visits as a Tool for Multi-Level Teaching of Professionalism in Medical Education

Onelia Lage, MD; David Tran, MD; Amal Bhullar, MD; Troy A. Stefano, PhD

Introduction

Professionalism — as a normative set of precepts, attributes, and behaviors that society, individual patients and practicing physicians expect of medical professionals — is a constitutive dimension of medicine as a profession.[1] In recent years, medical societies, accrediting organizations and health care institutions have addressed professionalism in important ways; but the specific methods by which to most effectively teach and develop professionalism remains a pressing challenge. In this article, we propose partnerships between medical schools and state medical boards in which medical students attend and reflect on state medical board disciplinary hearings to supplement ethical and professional curricula as a tool for multi-level teaching of professionalism in medical education. Several studies suggest an association between unprofessional behaviors that occur during medical school and state boards disciplinary hearings.[2,3,4] While the idea of a collaboration between state medical boards with medical schools has been proposed and piloted before — and is currently practiced by some state medical boards — this article offers a rationale for such collaboration from the perspective of medical students who have actually engaged in the process.

Framing the Challenge of Teaching Professionalism

Balancing the Abstract and the Concrete

Professionalism is an abstract concept, which intrinsically denotes a mode of ethical conduct that is concrete, situational and oriented towards the formation of professional identity. This creates an essential tension between the three poles of abstract principle, concrete context and personal identity that underline the challenge of teaching and assessing professionalism.

First, as an abstract concept, scholars note that professionalism is difficult to grasp and explain.[1] The reason is not because of a lack of determinacy or relevance, but because of the breadth of content. Professionalism provides physicians with the values and ethical reasoning by virtue of which to conduct their activities and orient their dispositions. As such, the Physician Charter on Medical Professionalism describes Professionalism as "the foundation of the social contract for medicine."[5,6] It is for this reason that medical societies do not define professionalism intrinsically but offer "lists of attributes and behaviors associated with professionalism" or that "manifest" it. [1]

Second, professionalism does not exist as such; rather, what we find in the world are individuals engaged in professional *activities*. The transition from abstract idea to existing reality occurs only by means of professional activities, which are situation-specific and particular. Thus, professionalism in medicine can apply to clinicians at any phase of training (learner, residents, fellows, physicians, and other health care professionals) and across diverse contexts.

Third, the movement from professionalism as an abstract concept to engaging in concrete professional activities entails a simultaneous movement toward defining a professional identity. Here professional identity refers to "clinicians' affinity for, acculturation into, and identification with the practice of medicine."[7,8] Professional activities become the indirect medium by which students transform from laypersons to medical professionals who personally bear and manifest the "roles, responsibilities, values, and ethical standards" of the medical profession.[8,9]

Historical Trends in Teaching Professionalism

Historically, ever since William Osler's revolutionary vision from 1903 to transform patients' bedsides into classrooms,[10] medical traineeship under clinician-educators was the primary pathway for learners' acculturation of professionalism. Implicit role-modeling and the professoriate of bedside teaching became the standard method of transmitting this skill for nearly a century.[11] This pedagogical method leaves the abstract aspect largely unformalized, emphasizing the practical aspects of professionalism. Efforts to distinguish between formal (e.g., manifest, conscious, deliberate) and informal (e.g., latent, unconscious, unintended) aspects of educational practices gained currency in the 1960s and 1970s and provided new resources for analyzing the complex mix of cultural, social and educational influence.[12,13]

Over the last 30 years, however, several major factors have led accrediting organizations, medical societies and health care institutions to call for a teaching, assessing and promoting of professionalism that is both intentional and explicit.[1] By contrast, researchers across the medical education spectrum have increasingly followed Frederic Hafferty's application of the concept of a "hidden curriculum" to medical education "to expose and explain a number of 'hidden' facets of learning and teaching."[14,15] Some of these key factors entail breaches of professionalism, both real and perceived, in medical and affiliated fields (e.g., financial conflicts of interest, fraud, inappropriate behaviors)[16] and increased awareness of the importance of professionalism for maintaining service quality (e.g., patients expect physicians to be professional),[17] improving medical outcomes,[18] and promoting business interests (e.g., indirectly driving revenues by positively affecting patient attraction, branding and philanthropic support).[1] Moreover, particularly after 1996, hospitalists (specialists in inpatient medicine) have increasingly replaced professors in the role of clinician-educators for trainees, contributing to curricular discontinuity, and sometimes conflict, between classroom and clinical environments.[11]

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Responsive to these and other concerns, the Accreditation Council for Graduate Medical Education (ACGME) includes professionalism as one of its six core competencies for practicing physicians.[19] The importance of professionalism is also recognized by the Association of American Medical Colleges and the American Medical Association, which places particular emphasis on interprofessional collaborative practice and professional responsibility, respectively.[20,21] The American Board of Internal Medicine gives professionalism special status, emphasizing patient welfare and autonomy along with social justice.[5-6] While today medical societies, accrediting organizations and health care institutions have addressed professionalism in important ways, the specific methods by which to most effectively teach and develop professionalism remains unsettled.

State Medical Board Visits as a Tool for Multi-Level Teaching of Professionalism in Medical Education

A persistent obstacle in teaching professionalism is the gap between abstract content and concrete application. Pedagogical guides sometimes sort teaching methods according to their focal point in terms of emphasis on the abstract (e.g., didactic, lecture-based activities, which are well-suited for communicating large amounts of information), or emphasis on the concrete (e.g., case-based study, simulations, role modeling, among others).[22] In other cases, professional identity is the focal point, or a combination of these.

State medical board disciplinary proceedings have the unique potential to bridge this gap and serve as an effective teaching tool — offering clinicians in training the opportunity to see actual first-hand examples of the role professionalism plays, on both an abstract and concrete level, in the work of licensed health care practitioners.

In this model, medical students attend state medical board hearings, where they learn the facts of cases being adjudicated. Seeing the reality of medical errors — accidental or not — along with examples of breaches of ethical conduct and the real-life consequences that can ensue from these issues tends to make a strong impression. Providing this candor as a part of the undergraduate medical curriculum could introduce a better understanding of the severity of the consequences when patient safety protocols and standards of care, both medical and ethical, are violated.

Further, structured courses or class sessions that provide actual scenarios involving both medical errors and ethical concerns via state medical board proceedings would also better prepare medical students for their later residency training.

Some medical schools and graduate programs for other health care professionals require that students attend at least one state licensing board meeting to understand a board's purpose and the intricacies of the regulatory process. While attending medical school at Florida International University Herbert Wertheim College of Medicine, two of the co-authors of this article — David Tran, MD, and Amal Bhullar, MD — were encouraged by a faculty mentor — Onelia Lage, MD, also a co-author of this article — to attend Florida Board of Medicine meetings as a supplement to their professional and ethical curriculum. Their co-written impressions of this experience

are shared here.

Reflections on a State Medical Board Visit

(David Tran, MD, and Amal Bhullar, MD)

As medical students, we spend the majority of our early days memorizing pathways, learning the pathophysiology of disease processes, how social determinants of health are related to them, and recalling treatment algorithms for the classic presentation of an illness. Later, we participate in patient care during our clerkships and advanced clinical rotations. Throughout this time, we are trenchantly focused on the most important test of our time in medical school: The United States Medical Licensing Examination (USMLE). As we prepare for this exam, perhaps we are often not thinking about some of the complexities that we will eventually encounter as practicing physicians as much as we should.

As time goes on, we grow into our shoes. We begin to develop a sense of confidence in ourselves as we progress in our education and practice our roles. Rather than the fumbling we experienced the first time we were told to pre-round on our patients, we have increasingly become confident in taking histories and physicals, talking to nurses for overnight changes, and presenting patients on rounds. Now, we not only fill out the shoe, but the shoe begins to fit us.

The Florida Board of Medicine holds regular disciplinary action meetings for licensee misconduct per Florida's statutes for grounds for board disciplinary action. During our time as medical students, we visited the Board several times. During our visits, we learned that issues can range from insurance fraud to medical negligence, from self- or family-prescribing of controlled substances to sexual misconduct. We attended several meetings but one stood out in particular. During the meeting, the Board considered a case in which communication and documentation errors led to the death of a patient. While the physician claimed to have prescribed one medication, the circulating nurse delivered a different medication. The nurse documented the medication as she heard it described. Medical personnel tried to perform resuscitation protocols to no avail. The patient died.

It was perhaps the fact that this case seemed so simple — harmless even — and yet resulted in the death of the patient that it struck us with a sense of existential urgency. This was not a "case study," a practicum, or yet another assessed interaction with a patient. This concerned matters of life and death, and this urgency led us to feel the weight of our aspiring roles as physicians more seriously. We also saw how interdependent health care professionals are in forming seamless communication and documentation and the way that a fragment in the lines of communication can have irrevocable consequences. Our attention was drawn to the degree of vulnerability on the patient's part in this situation. Although trust was frequently spoken about in classes, we did not realize so starkly the degree of trust implied on the patient's side, as can be seen by the extent to which the patient is vulnerable in the physician's care.

As we thought about the patient's vulnerability and the physician's seeming lack of remorse or affect, we were struck by the role of the Board members. Who do they represent in enforcing the statutes regulating the practice of medicine? It became clear by the way they spoke that they represent the expectations that physicians have of their own profession. As the proceeding continued, it also became clear that they took upon themselves the role of representing the interests and representatively bearing the trust of the (deceased) patient. We not only saw the sort of things and practices we want to avoid or prevent in the case of the disciplined licensee but the sort of physicians we want to be in the figure of the Board.

Looking over our experiences and developments in light of our attendance at the Florida Board of Medicine meetings, it is clear to us that training should not stop once the core skills of medicine are obtained. Competence and confidence are necessary,

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but not sufficient goals. We need to go beyond that. Medical students must be trained to act in their patients' interest and to protect their patients, colleagues, and themselves, as well as their employers, from harm and/or compromising medico-legal situations.

Our visits to these meetings also made us realize the need to better prepare medical students to understand the statutory and legal aspects of medical practice insofar as their actions (or inactions)

can implicate them and those affiliated with them in legal or regulatory proceedings.

Conclusion

The comments of Dr. Tran and Dr. Bhullar implicitly touch upon the abstract, concrete and professional-identity aspects of professionalism, suggesting that visits to state medical board disciplinary hearings can help shape valuable reflective experiences.

Some medical schools already require students to attend at least one state medical board meeting as part of their professional and ethical education curriculum. Such programs hold enormous promise for multi-level teaching of professionalism in medical education. As this relatively untapped frontier continues to grow, it will be essential to develop the requisite research protocols to track its effectiveness. ■

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References

1. Mueller PS. Teaching and Assessing Professionalism in Medical Learners and Practicing Physicians. *Rambam Maimonides Med J.* 2015 Apr 29;6(2):1-13. http://doi.org/10.5041/RMMJ.10195.
2. Fargen KM, Drolet BC, Philibert I. Unprofessional behaviors among tomorrow's physicians: review of the literature with a focus on risk factors, temporal trends, and future directions. *Acad Med* 2016;91:858–64.
3. Papadakis MA, Teherani A, Banach MA, et al. Disciplinary action by medical boards and prior behavior in medical school. *N Engl J Med* 2005;353:2673–82.
4. Papadakis MA, Hodgson CS, Teherani A, Kohatsu ND. Unprofessional behavior in medical school is associated with subsequent disciplinary action by a state medical board. *Acad Med* 2004;79:244–9.
5. ABIM Foundation, ACP-ASIM Foundation, European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med* 2002;136:243–6.
6. Blank L, Kimball H, McDonald W, Merino J, ABIM Foundation, ACP Foundation, European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter 15 months later. *Ann Intern Med* 2003;138:839–41.
7. Dutton JE, Dukerich JM, Harquail CV. Organizational images and member identification. *Admin Sci Q.* 1994;39:239-63.
8. Iserson KV. Talking about Professionalism Through the Lens of Professional Identity. *AEM Education and Training* 2019;3:105-112.
9. Golz HH, Smith ML. Forming and developing your professional identity easy as PI. *Health Promot Pract* 2014;15:785-9.
10. Osler W. The hospital as a college. In: Osler W. *Aequanimitas: With Other Addresses to Medical Students, Nurses and Practitioners of Medicine*. Philadelphia, PA: P. Blakiston's Son; 1905:327-342.
11. McCarthy MW, Fins JJ. Teaching Clinical Ethics at the Bedside: William Osler and the Essential Role of the Hospitalist. *AMA J Ethics*. 2017;19(6):528-532. http://doi.org/10.1001/journalofethics.2017.19.6.peer2-1706.
12. Strodtbeck FL. The hidden curriculum in the middle-class home. In: Krumboltz JD, ed. *Learning and the Education Process*. Chicago, Ill: Rand McNally; 1965.
13. Snyder BR. *The Hidden Curriculum*. New York, NY: Alfred A. Knopf; 1971.
14. Hafferty FW. Beyond curriculum reform: Confronting medicine's hidden curriculum. *Acad Med.* 1998; 73:403–7. [PubMed: 9580717].
15. Lawrence C, Mhlaba T, Stewart KA, Moletsane R, Gaede B, Moshabela M. The Hidden Curricula of Medical Education: A Scoping Review. *Acad Med.* 2018;93(4):648-656. http://doi.org/10.1097/ACM.0000000000002004.
16. Martimianakis MA, Michalec B, Lam J, Cartmill C, Taylor JS, Hafferty FW. Humanism, the Hidden Curriculum, and Educational Reform: A Scoping Review and Thematic Analysis. *Acad Med.* 2015 Nov;90(11 Suppl):S5-S13. http://doi.org/10.1097/ACM.0000000000000894.
17. Bendapudi NM, Berry LL, Frey KA, Parish JT, Rayburn WL. Patients' perspectives on ideal physician behaviors. *Mayo Clin Proc* 2006;81:338–44.
18. Brennan MD, Monson V. Professionalism: good for patients and health care organizations. *Mayo Clin Proc* 2014;89:444–52.
19. Accreditation Council for Graduate Medical Education's (ACGME) Core Competencies. Adopted in 1999. Also adopted by American Board of Medical Specialties, specific ABMS Boards, and numerous academic healthcare centers. Philadelphia: ECFMG/GEMx, 1999.
20. Interprofessional Education Collaborative Expert Panel. Core competencies for interprofessional collaborative practice: Report of an expert panel. Interprofessional Education Collaborative; 2011; Washington, D.C.
21. American Medical Association. Declaration of Professional Responsibility. 2000:144–145. Appendix In: Council on Ethical and Judicial Affairs. Code of Medical Ethics –Current Opinions, 2000–2001 Edition, xiv. Chicago: American Medical Association.
22. O'Sullivan H, van Mook W, Fewtrell R, Wass V. Integrating professionalism into the curriculum: AMEE Guide No. 61, Med Teach. 2012;34:2, e64-e77, http://doi.org/10.3109/0142.