Evaluating your professionalism

What does being professional look like? Does it mean that you do the 'right' thing, even when no-one is looking? How do you evaluate your professionalism knowledge, values and behaviour? How do you identify and address underperformance in professionalism? How can you transfer your professionalism to different circumstances?

The term 'professional' derives from the notion of an occupation or vocation that one 'professes' to be capable in as well as 'a vocation with a body of knowledge and skills (expertise) put into service for the good of others; the welfare of society', but has also become associated with meeting the standards required of a statutory regulatory body.

There are numerous definitions of professionalism, reflecting its multidimensional and complex nature. It has been defined as 'the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served' (Epstein and Hundert, 2002). Increasingly professionalism is associated with an individual's evolving 'professional identity' – the beliefs and values that underpin how individuals define and view themselves as a professional (Cruess et al, 2015). However, professionalism has also been described as a continuum, extending beyond the individual to include interpersonal and societal elements, including interactions with others, social responsibility and morality (Hodges et al, 2011). It can also include a requirement to work collectively as a profession to debate, establish and enforce standards (Wynia et al, 2014).

What is clear is that you cannot describe yourself as being professional, as that is determined by the perceptions that others have of you (Maister, 2000). It is not professional to hide behind a claim of being a professional to excuse an inappropriate action or inaction. The quintessential professional used to be a white man in a suit and tie, with a congenial smile and an authoritarian paternalistic style. Clearly the concept of what qualifies as professional has changed, and is determined by norms which change over time (Hilton and Southgate, 2007; van Mook et al, 2009a). Within clinical practice there has been a shift from paternalism to co-construction, through psychological, social, cultural and political processes. Being professional is not the job you do or what you look like, it is how you do the job and how you are perceived by others. Furthermore what is required of you can be expected to change. Being professional does not depend on being a qualified member of a regulated profession (although retaining professional registration does depend on being professional). Indeed people do not need to belong to an established profession to hold professional values and have a professional work ethic. Thus within medicine it is not enough to be qualified, registered and keep up-to-date with General Medical Council (2013) guidelines; it is also important to continuously develop your own professional identity and ensure that your practice complies with the expectations of others.

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Professional attributes

When observing others do you recognize professionalism when you see it? Is it easier to recognize unprofessional behaviour? People expect a professional to act as their advocate. They need to know that you share the same goals, care about what is important to them, and will always strive to serve their best interests – to the best of your ability and whatever the circumstances. Thus doing the 'right' thing is about being considerate of others.

There are many lists of qualities associated with being professional (Wynia et al, 2014; *Table 1*). Key attributes include exhibiting ethical principles, having integrity, and being reliable and responsive. It is essential to have effective interactions with staff and patients, and with any other people who are important to patients. It is also necessary to demonstrate insight into your own health (Wilkinson et al, 2009) and self-regulate your availability to others whenever your ability to take professional responsibility may be compromised. To maximize success you need to reflect on practice and be committed to improvement of competence in yourself, others and systems.

Aims of professionalism

First, there is a need to ensure minimum standards for registration and revalidation (General Medical Council,

2012). Second, assessment of professionalism is important to identify gaps and lapses, and direct to remediation as appropriate. Finally, assessment is also necessary to promote high standards and facilitate development. Assessment or measurement is difficult because of the different elements of professionalism, the different methods required, and the consequent tension between identifying minimum competence (to ensure safety), promoting high levels of capability (Neve and Hanks, 2016) and ranking (to encourage development; Archer et al, 2015).

How can professionalism be measured?

With a wide variety of key attributes, it is clear that multiple methods of measurement are required (Hawkins et al, 2009; Hodges et al, 2011; Lockyer, 2013). Each attribute needs clear criteria for making judgements at the boundaries of unsatisfactory and excellent performance. If gradations or degrees of transgression can be identified then the attribute can be measured on a scale and benchmarked. High and low standards need to be qualified, with descriptive criteria to aid judgements. Furthermore events need to be triangulated (i.e. transgressions corroborated by multiple sources or independent incidents), and have the scope to accumulate over time, to provide evidence relevant to practice (van Mook et al, 2009a–g).

Each event should have an associated record of its magnitude and frequency, supported by the individual's rationale for his/her action(s), along with the total volume of uneventful equivalent professional interactions. This enables the number of transgressions to be expressed against the number of opportunities within a similar context when such a transgression could have occurred but did not (e.g. three formal complaints of being rude in an outpatient clinic from three separate patients spread over 6 years against a background of 9000 outpatient appointments over that period without any other problem on record). The incidence of adverse events enables comparison with professional norms, but records of good behaviour should not be used to negate or justify bad behaviour. There must be transparent links to fitness to practise procedures as appropriate (General Medical Council, 2014). Measurement should be 'unscheduled' as well as 'scheduled', with a formative opportunity before the first summative measurement, be it by staff in different categories, peers and self, as well as senior staff and patients (Ginsburg et al, 2000), and above all be longitudinal (Goldie, 2013).

Professionalism is very hard to assess well, particularly in complex real world settings, and there is no gold standard. There is evidence for dozens of different tools which can be used to assess professionalism (Wilkinson et al, 2009). Most tools rely on observable behaviours (Rodriguez et al, 2012), and there is not much evidence supporting their interpretation (Ginsburg et al, 2000; Lynch et al, 2004), although a framework has more recently been developed to establish validity (Holtman, 2008; Clauser et al, 2012). Values and behaviour differentiate between thinking and doing, and values can be mimicked by changing behaviour to conform to expected norms. Often the only evidence of transgression is a subjective view from a single individual, lacking independent corroboration. Integrating professionalism with measures of other aspects of practice provides a more holistic assessment, but single incidents can then influence multiple decisions about an individual's wider performance (i.e. risking double jeopardy). Particular aspects which are of repeated concern are failure to accept constructive criticism and unreliable attendance (Papadakis et al, 2005), suggesting a lack of ownership and insight into their problem.

Table 1. Qualities associated with professionalism

Considerate of others and assertively manages risk to act in their best interests
Appropriate ethical conduct in different situations
Interacts and engages effectively with colleagues, patients and others
Honest, trustworthy and keeps his/her word; being dependable
Does not use good behaviour to justify bad behaviour
Has insight into his/her own health and can appropriately regulate his/her availability to others
Mindful, emotionally controlled and resilient
Reflects on practice, acts on constructive criticism, and committed to autonomous improvement
Ability to work with uncertainty and complexity and adapt his/her professionalism as needed

Assessing professionalism implies quantification. Yet reducing professionalism to numbers may not reflect 'the richness of real-life clinical medicine' and such assessments risk being invalid (Amin, 2012). Assessors should be well trained but may need some freedom to use their judgment where assessing hard to define behaviours. If professionalism is quantified then it will result in the ranking of individuals; this promotes competition which could undermine teamwork. One way of overcoming this would be to assess the performance of a team as a whole. This would reflect the real world where the quality of care is often more dependent on a team than on an individual. As part of this staff could rate how each member (including themselves) has contributed to the team. In order to maximize the success of one's individual contribution within a multidisciplinary team it is therefore important to know not only the professional governance arrangements of the relevant allied professions but also their skills, experience and expectations.

Can professionalism be taught and learnt?

Are bad people born bad? Will bad people will always be bad? Do prospective professionals all begin their training with the same level of professionalism? If the answer to these questions is no, then clearly professionalism is not innate but a product of experiential conditioning. Different backgrounds and ethnographic norms give rise to different starting points. As such, deficits can be identified and improved upon.

Table 2. Experiences which could transform core values and differences in their context	
Transformational experiences	Altruism
	Death
	Birth
	Deprivation
	Discrimination
	Pain
	Success/failure
	Mistakes
	Stoicism
	Revelatory feedback
Reasons for different impacts and degrees of assimilation	Number of occurrences
	Combination of experiences
	Order of exposures
	Magnitudes
	Time intervals
	States of receptiveness

How can professionalism be improved?

Strategies to improve professionalism require knowledge of expected professional norms, along with explanation to convey understanding of the reasons for the requirements to improve engagement, e.g. relating to boundaries between personal and professional life (Lapid et al, 2009) and formal *vs* informal encounters (Monrouxe and Rees, 2012). Exposure to role models, 360° feedback and significant formative experiences can be transformational (Pearson and Hoagland, 2010; Stupans et al, 2011; Wilson et al, 2013), particularly where opportunities are provided to promote reflection on these (Mann et al, 2009). Reflective practice, alone and in groups, should be encouraged and can be improved by providing facilitation and feedback (Camp et al, 2010), and facilitating group review of dilemmas (Bernabeo et al, 2013). Inferior reflective practice correlates with inferior peer ratings (Wittich et al, 2013). Being non-judgementally receptive to feedback is in itself an element of professionalism; learning from the perceptions of others is an important way of increasing what we know about ourselves (Luft and Ingham, 1955). Core values can not easily be changed without providing experiences to develop sympathy and where reasonable empathy (*Table 2*). Motivation to develop can also be provided by monitoring (General Medical Council, 2012) and knowledge of the regulatory fitness to practise sanctions (General Medical Council, 2015). However, it is important not to rely on the threat of punishment to ensure conformity, but to use praise wherever possible to encourage development (O'Sullivan et al, 2012).

Factors affecting professionalism judgements

Clinicians all undertake different journeys of professionalism from novice, through competency and proficiency, to expert (Dreyfus, 2004). Excellence in professionalism depends more on flexibility, motivation and social competence than technical expertise (Lindberg and Rantatalo, 2014). Professional capability ensures the transfer and integration of appropriate behaviours between different settings. To assess this requires empathy for the context, conflicting demands and stressors (Ginsburg et al, 2000; Holtman, 2008). The appropriateness of any given professional decision and action will depend on the circumstances of all concerned. There may be mitigating factors which may indicate whether an incident is an isolated lapse or a pattern of persistent misconduct which brings the profession into disrepute.

Training of assessors is vital. Wherever possible knowledge of existing transgressions should not influence the reporting of new events to ensure that longitudinal records are unbiased. Different perspectives (e.g. peers and other grades of own profession and other professional groups, patients and members of the public) can be useful in determining the significance of events. Individual opinions may differ on the appropriateness of a particular behaviour, with perspectives influenced by status, stakes, support availability, time pressures and ethnographies.

Principles common to other regulated professions, e.g. pilots (Birden et al, 2013) and the police (College of Policing, 2014) include etiquette, safety, reliability, engagement, self-improvement and risk management. Successful risk taking needs to be identified and shared (College of Policing, 2013). When managing uncertainty, excessive penalisation of mistakes leads to risk aversion and delayed action as the default decision. Hesitation is associated with its own dangers. Nevertheless it is important not to trust one's intuition unconditionally (Kahneman, 2011). Intuition can be accentuated by emotions (Leffel et al, 2015), and this should be reflected upon. It is important to recognize gut feelings, and challenge oneself to think critically about why one might be experiencing them. Always try to be mindful of one's own unconscious confirmation bias, and look for objective evidence on which to base decisions (Leung et al, 2011). To overcome inertia it is necessary to decide what action to take based on the evidence available in that moment, to protect and help others, without being influenced by personal self-interest. **BJHM**

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Amin Z (2012) Purposeful assessment. *Med Educ* **46**(1): 4–7

Archer J, Regan de Bere S, Nunn S et al (2015) No one has yet properly articulated what we are trying to achieve: a discourse analysis of interviews with revalidation policy leaders in the United Kingdom. *Acad Med* **90**(1): 88–93 (doi: 10.1097/ACM.0000000000000464)

Bernabeo EC, Holmboe ES, Ross K et al (2013) The utility of vignettes to stimulate reflection on professionalism: theory and practice. *Adv in Health Sci Educ* **18**: 463–84 (doi: 10.1007/s10459-012-9384-x)

Birden H, Glass N, Wilson I et al (2013) Teaching professionalism in medical education: a best evidence medical education (BEME) systematic review. BEME Guide No.25. *Med Teach* **35**: 1252–66

Camp CL, Gregory JK, Lachman N et al (2010) Comparative efficacy of group and individual feedback in gross anatomy for promoting medical student professionalism. *Anat Sci Educ* **3**(2): 64–72

KEY POINTS

- Professionalism is a norm-referenced construct, which changes over time and context.
- Doing the right thing is about being considerate of others.
- Evaluation requires triangulation from multiple sources at multiple times.
- Misconduct depends on magnitude, frequency and volume, as perceived by others.
- Deficits can be identified and improved upon.
- Changing values depends on receptiveness to transformational experiences.
- Behaviour can be influenced by context and perceived risks.
- It is vital to promote high standards of professionalism, not just ensure minimum standards.

Clauser BE, Margolis MJ, Holtman MC et al (2012) Validity considerations in the assessment of professionalism. *Adv in Health Sci Educ* **17**: 165–81 (doi: 10.1007/s10459-010-9219-6)

College of Policing (2013) Risk. www.app.college.police.uk/app-content/risk-2/risk/ (accessed 20 January 2016)

College of Policing (2014) *Code of ethics: A Code of Practice for the Principles and Standards of Professional Behaviour for the Policing Profession of England and Wales.* College of Policing Limited, Coventry: 1–34

Cruess RL, Cruess SR, Boudreau JD et al (2015) A schematic representation of the professional identity formation and socialization of medical students and residents: A guide for medical educators. *Acad Med* **90**(6): 718–25

Dreyfus SE (2004) The five-stage model of adult skill acquisition. *Bull Sci Technol Soc* **24**: 177–81

Epstein RM, Hundert EM (2002) Defining and assessing professional competence. *JAMA* **287**(2): 226–35

General Medical Council (2012) *Supporting information for appraisal and revalidation.* General Medical Council, London: 1–16

General Medical Council (2013) *Good medical practice.* General Medical Council, London: 1–36

General Medical Council (2014) *The meaning of fitness to practise.* General Medical Council, London: 1–3

General Medical Council (2015) *Sanctions guidance.* General Medical Council, London: 1–41

Ginsburg S, Regehr G, Lingard L (2000) Basing the evaluation of professionalism on observable behaviors: a cautionary tale. *Acad Med* **79**(10): S1–S4

Goldie J (2013) Assessment of professionalism: A consolidation of current thinking. *Med Teach* **35**: e952–e956 (doi: 10.3109/0142159X.2012.714888)

Hawkins RE, Katsufrakis PJ, Holtman MC, Clauser BE (2009) Assessment of medical professionalism: Who, what, when, where, how, and … why? *Med Teach* **31**: 348–61 (doi: 10.1080/01421590902887404)

Hilton S, Southgate L (2007) Professionalism in medical education. *Teach Teach Educ* **23**: 265–79 (doi: 10.1016/j.tate.2006.12.024)

Hodges B, Ginsburg S, Cruess R et al (2011) Assessment of professionalism: recommendations from the Ottawa 2010 Conference. *Med Teach* **33**: 354–63 (doi: 10.3109/0142159X.2011.577300)

Holtman MC (2008) A theoretical sketch of medical professionalism as a normative complex. *Adv Health Sci Educ* **13**: 233–45 (doi: 10.1007/s10459-008-9099-1)

Kahneman D (2011) *Thinking, Fast and Slow.* Farrar, Strauss, Giroux, New York

Lapid M, Moutier C, Dunn L et al (2009) Professionalism and ethics education on relationships and boundaries: psychiatric residents' training preferences. *Acad Psychiatry* **33**(6): 461–9

Leffel GM, Oakes Mueller RA, Curlin FA, Yoon JD (2015) Relevance of the rationalist–intuitionist debate for ethics and professionalism in medical education. *Adv Health Sci Educ* **20**: 1371–83 (doi: 10.1007/s10459-014-9563-z)

Leung YL, Adesara S, Burr SA (2011) Learning to make better clinical decisions. *Br J Hosp Med* **72**(11): 642–5 (doi: 10.12968/hmed.2011.72.11.642)

Lindberg O, Rantatalo O (2014) Competence in professional practice: A practice theory analysis of police and doctors. *Human Relations* (doi: 10.1177/0018726714532666)

Lockyer J (2013) Multisource feedback: can it meet criteria for good assessment? *J Contin Educ Health Prof* **33**(2): 89–98 (doi: 10.1002/chp)

Luft J, Ingham H (1955) The Johari window, a graphic model of interpersonal awareness. Proceedings of the western training laboratory in group development. University of California, Los Angeles

Lynch DC, Surdyk PM, Eiser AR (2004) Assessing professionalism: a review of the literature. *Med Teach* **26**(4): 366–73 (doi: 10.1080/01421590410001696434)

Maister DH (2000) *True Professionalism: The Courage to Care about Your People, Your Clients, and Your Career.* Free Press, New York: 210

Mann K, Gordon J, MacLeod A (2009) Reflection and reflective practice in health professions education: a systematic review. *Adv Health Sci Educ* **14**(4): 595–621

Monrouxe LV, Rees CE (2012) "It's just a clash of cultures": emotional talk within medical students' narratives of professionalism dilemmas. *Adv Health Sci Educ* **17**: 671–701 (doi: 10.1007/s10459-011-9342-z)

Neve H, Hanks S (2016) "When I say…capability." *Med Educ* **50**(6): 610–11 (doi 10.1111/medu.12956)

O'Sullivan H, van Mook W, Fewtrell R, Wass V (2012) Integrating professionalism into the curriculum: AMEE Guide No. 61. *Med Teach* **34**: e64–e77 (doi: 10.3109/0142159X.2012.655610)

Papadakis M, Teherani A, Banach M et al (2005) Disciplinary action by medical boards and prior behavior in medical school. *N Engl J Med* **353**: 2673–82 (doi: 10.1056/NEJMsa052596)

Pearson WG, Hoagland TM (2010) Measuring change in professionalism attitudes during the gross anatomy course. *Anat Sci Educ* **3**: 12–16

Rodriguez E, Siegelman J, Leone K, Kessler C (2012) Assessing professionalism: summary of the working group on assessment of observable learner performance. *Acad Emerg Med* **19**(12): 1372–8 (doi: 10.1111/acem.12031)

Stupans I, Scutter S, Sawyer T (2011) Fostering professionalism through scaffolding in first year clinical placements. *Innovations in Education and Teaching International* **48**(3): 263–74 (doi: 10.1080/14703297.2011.593703)

van Mook WN, de Grave W, Wass V et al (2009a) Professionalism: Evolution of the concept. *Eur J Int Med* **20**: e81–e84 (doi: 10.1016/j.ejim.2008.10.005)

van Mook WN, van Luijk SJ, O'Sullivan HM et al (2009b) The concepts of professionalism and professional behaviour: Conflicts in both definition and learning outcomes. *Eur J Int Med* **20**: e85–e89 (doi: 10.1016/j.ejim.2008.10.006)

van Mook WN, van Luijk SJ, O'Sullivan HM et al (2009c) General considerations regarding assessment of professional behaviour. *Eur J Int Med* **20**: e90–e95 (doi: 10.1016/j.ejim.2008.11.011)

van Mook WN, de Grave WS, van Luijk SJ et al (2009d) Training and learning professionalism in the medical school curriculum: current considerations. *Eur J Int Med* **20**: e96–e100 (doi: 10.1016/j.ejim.2008.12.006)

van Mook WN, Scheltus J, van Luijk SJ et al (2009e) Teaching and learning professional behavior in practice. *Eur J Int Med* **20**: e105–e111 (doi.org/10.1016/j.ejim.2009.01.003)

van Mook WN, Gorter SL, O'Sullivan HM et al (2009f) Professionalism beyond medical school: An educational continuum? *Eur J Int Med* **20**: e148–e152 (doi: 10.1016/j.ejim.2009.09.009)

van Mook WN, Gorter SL, O'Sullivan HM et al (2009g) Approaches to professional behaviour assessment: tools in the professionalism toolbox. *Eur J Int Med* **20**: e153–e158 (doi: 10.1016/j.ejim.2009.07.012)

Wilkinson T, Wade W, Knock L (2009) A blueprint to assess professionalism: results of a systematic review. *Acad Med* **84**: 551–8

Wilson A, Åkerlind G, Walsh B et al (2013) Making 'professionalism' meaningful to students in higher education. *Studies in Higher Education* **38**(8): 1222–38 (doi: 10.1080/03075079.2013.833035)

Wittich CM, Pawlina W, Drake RL et al (2013) Validation of a method for measuring medical students' critical reflections on professionalism in gross anatomy. *Anat Sci Educ* **6**(4): 232–8

Wynia MK, Papadakis MA, Sullivan WM, Hafferty FW (2014) More than a list of values and desired behaviors: a foundational understanding of medical professionalism. *Acad Med* **89**(5): 712–14 (doi: 10.1097/ACM.0000000000000212)