CFMS FEMC

Canadian Federation of Medical Students

Fédération des étudiants et des étudiantes en médecine du Canada

CFMS Guide to Medical Professionalism

Being a student professional

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INTRODUCTION

During the CFMS 2009 Annual General Meeting in Thunder Bay, Ontario, the CFMS VP Education was mandated to conduct some primary research, propose a framework and develop initial guidelines surrounding medical student professionalism. The goal of these guidelines was the following:

- To provide a universally accepted framework for medical student professionalism
- To provide Canadian medical student societies with professionalism frameworks that could be used to drive local grass roots policies
- To demonstrate the will of Canadian medical students to participate in the discussions surrounding professionalism
- To continue to maintain foresight regarding student professionalism issues in Canada
- To address emerging and perceived realms of personal identity through the lens of the medical student

Traditionally, Canada leads the international community in its ability to foresee and predict new trends in medical education. Our country continues to produce programs and models to international acclaim; examples of such programs include the CanMEDS roles and the Royal College curriculum surrounding physician health. However, in the realm of professionalism, Canada is lagging behind when it comes to a nationally accepted professionalism framework at the physician level. Currently, the CMA Committee on Education and Professional Development (CEPD) as well as the Medical Council of Canada (MCC) are working to develop such models for the physician workforce, following closely in the footsteps of the UK, the USA, Australia and New Zealand. Understandably, the forces that govern a future professionalism policy are hard at work.

Interestingly, the search for medical student specific professionalism guidelines in these same countries and organizations turns up little of substance, with one exception. The General Medical Council (GMC) of the UK developed a document entitled “Medical Students: professional values and fitness to practice”, a student specific guide on professionalism. The GMC is the licensing body for all medical practitioners in the UK. This document was drafted by the Medical Schools Council (MSC), a subcommittee of the GMC which consists of representation from all 32 medical schools in the UK.

Perhaps due to this unique structure, or a myriad of other unknown reasons, the GMC has succeeded in producing a high quality document which clearly enumerates the boundaries of professionalism and provides students with an important guideline for their own scope of practice and responsibility to health care. But the GMC guide goes one step further in that it is also destined to be a disciplinary and regulatory document for all issues within the realm of student

fitness to practice. This is easily permitted given the nature and structure of the MSC and GMC.

However, the CFMS does not endeavor to enter into disciplinary territory with this guide, nor do we pretend to have the expertise to intelligently address disciplinary issues. Instead, the power of this guide is that it will have been student written, student driven, student approved and student powered. In this, the "CFMS guide to student professionalism" will be internationally unique. This document will draw the boundaries of professionalism for medical students and will shed some light in its darker corners. Furthermore, we seek to provide some basic strategies to allow students to monitor their professionalism as well as help achieve consensus regarding "virtual identities" as real time users.

And as we have pushed forward with professionalism, we have chosen to look at the issue through a truly Canadian lens. Using the CanMEDS roles and describing student professionalism in each realm makes this report taste decidedly Canadian, allows us to clearly separate and delineate each of these roles in ourselves as medical students and will undeniably allow for easier consideration and implementation at faculty levels as individual curricula are moving themselves towards the CanMEDS model.

The production of this report is a source of pride for all that are involved, to all CFMS members and to the Canadian medical community. Through much iteration, this report has accumulated the perspective of students from across the country and the ratification of this document will be both an act of great astuteness on the part of our medical students as well as an act of professionalism in itself.

Our ability to flex and move rapidly, avoiding overly structured ratification mechanisms makes all student organizations unique and strong. This also makes this guide particularly relevant, as it is more apt to reflect the changing times. This guide is largely a plastic foundation, meant to be built upon when future issues of professionalism arise, as they undoubtedly will. As long as this document remains student reviewed and driven, it will be pertinent to medical education in Canada.

EXECUTIVE SUMMARY

The CFMS does not endeavour to enter into disciplinary territory with this guide, nor do we pretend to have the expertise to intelligently address disciplinary issues. Instead, the power of this guide is that it will have been student written, student driven, student approved and student powered.

MEDICAL EXPERT

To further themselves as medical experts, medical students:

- Must be aware of the lifelong nature of the information that they are expected to study and solidify as learners.
- Will understand the limited scope in which they practice and will operate within these boundaries.
- Will use their clinical years to adequately transition their theoretical knowledge to more applied, clinical health care practices.

THE SCHOLAR

To further themselves as scholars, medical students:

- Must demonstrate a commitment to be aware of new and emerging guidelines and knowledge for clinical care and endeavour to develop critical appraisal skills in order to accumulate their own evidence-based tools and information.
- Attend all mandatory teaching sessions and complete all course work. Any exceptions should be adequately communicated to and approved by faculty
- Respect all teachers and preceptors as clinicians and individuals and to respect personal and professional boundaries between faculty and teaching members and the student body so as to engage in only proper professional relationships with teaching and faculty members
- Will be aware of industry influence and perceived influence in the medical profession and will not engage in any activity that could be perceived to affect patient care or student wellbeing.
- Be aware of the process and principles of medical education locally
- Be willing to contribute to the education of others in the medical community
- Give constructive and respectful feedback on the quality of learning and teaching sessions, clinical placements and preceptor performance

THE COMMUNICATOR

To further themselves as communicators, medical students:

- Should build relationships with patients through honest communication that conveys appropriate respect and compassion.

- Must retain professional boundaries between themselves and patients or anyone close to the patient. Any relationship based on anything beyond treatment and management of the patient's condition can be considered unprofessional.

- Shall ensure informed consent for every clinical encounter, procedure or discussion that is performed or observed by a medical student. For institutions that are clearly identified as learning centers, implied consent may be assumed for student participation in the patients' care however the student is still responsible to clearly identify themselves as a medical student.

- For the sake of clarity, the CFMS would advise medical students to refrain from the term *clinical clerk* in favour of the much more widely understood *senior medical student*.

- Will operate under the premise of full disclosure with the patient at all times. This includes disclosure of medical error or adverse events. Medical students will only offer information that is congruent with their level of training.

- Are expected to uphold the highest standards of medical confidentiality regarding patient care. A patient's case cannot be discussed in any way in which they may be identified.

- Will understand that all communications they issue, in the professional or personal setting including on the Internet or in social media, directly reflects on their personal professionalism and also allows for inferences into their medical professionalism. For more information regarding digital media, please see Appendix A of the CFMS Professionalism Policy.

- Should dress appropriately and professionally and accept that patients will respond to their appearance, presentation and hygiene.

- Report any breaches in professionalism, harassment, inappropriate or unprofessional behaviour directed toward any student or patient by other members of the health care team.

- Be available for any communication regarding their responsibilities or education

THE COLLABORATOR

To further themselves as collaborators, medical students:

- Will commit to developing skills to work in interdisciplinary teams.
- Medical students will protect patients from harm posed by another colleague's behaviour, performance or health.
- Medical students will not engage in any gender, sexual or cultural biases and endeavour to create a positive space in the workplace at all times.
- Will commit to the concept of shared decision making with all members of the health care team as well as the patient and their family.

THE PROFESSIONAL

To further themselves as professionals, medical students:

- Will ensure that their behaviour, at all times, justifies the trust that the patient and the public place in medical practitioners and the medical profession. Medical students will not only reflect on their behaviour but will also reflect on the perception that the public could draw from this behaviour and act within the boundaries of public trust. It should be noted that certain behaviours that could be considered unprofessional when conducted in public are not automatically unprofessional in all settings. A behaviour that is unprofessional in public may be completely acceptable with done in a students' private life so long as it does not draw undue attention to the medical community.
- Are advised to partake in social opportunities that facilitate networking with their colleagues. Immersing oneself in festivities and traditions can be an important method of fostering professional relationships that will aide patient care in the future.
- Shall Readily call attention to errors or concerns about their own clinical work
- Produce academic works that are, in all aspects, their own and will raise issue when there are concerns regarding the honesty of others.
- When faced with concerns about a colleague's actions, shall first approach the colleague with those concerns (whenever possible). If the colleague cannot satisfactorily appease the concern, then the student shall approach the appropriate authority.

- Be honest, trustworthy and punctual when recording clinical activities and procedures, in the completion of teacher, preceptor and class evaluation forms and in their CVs and application, including residency applications.

- Cooperate in the investigation of any medical, performance, behavioural or health related incidents, whether concerning themselves or any other members of the health care team

- With particular health concerns and conditions (including psychiatric illness, addiction and substance abuse) will, through the help of anonymous faculty services, seek out specialized care by the most suitably qualified professional.

- Who are beginning training rotations in culturally unique or foreign locations will attend cultural information and training sessions provided by their faculty.

- Protect their colleagues and patients by being immunized against common communicable diseases as judged appropriated by the faculty of medicine or practicing institution

- Will commit to understanding the principles of legal and bioethical practice as a medical doctor as outlined by the Canadian Medical Association.

- Medical students will uphold the highest values of integrity and honesty in their financial dealings. This includes financial obligations that are a requirement of medical education, local society dues, professional society dues, elective and application costs as well as any other personal or professional financial engagement.

THE ADVOCATE

In furthering themselves as advocates, medical students:

- Will remain, before any other role, advocates for appropriate high quality patient care and the highest standards of patient safety.

- Will develop skills and modalities that will help the learner in present and future advocacy and initiatives of population and community health.

- Will understand the influence and authority of their role in the patient's eyes.

THE MANAGER

In further themselves as manager, medical students:

- Should recognize that they are often the most visible and accessible part of the health care team to patients. Students must realize that patients often feel as though students are in a position of responsibility when it comes to their care. The medical student's personal opinion and all communications to the patient must be weighed in this light.

- Medical students will not conduct independent decision-making in the treatment course of a patient without senior qualified clinical approval.

- Will not conduct independent decision-making in the treatment course of a patient without senior qualified clinical approval.

Appendix A: Digital Media and Medical Professionalism

The CFMS recommends the following as appropriate steps in addressing professionalism in digital media:

1) Training institutions should commit to establishing familiarity amongst faculty of digital media.

2) Students and faculty should come together to jointly draft online professionalism policies to be followed at their local campus.

3) These parties should also develop digital media professionalism curricula for all students through whichever education vector deemed appropriate, digital or otherwise.

4) The CFMS recommends that all medical students subscribe to online services which will provide notices any time their name is published online. This is easily done through Google Alerts online service.

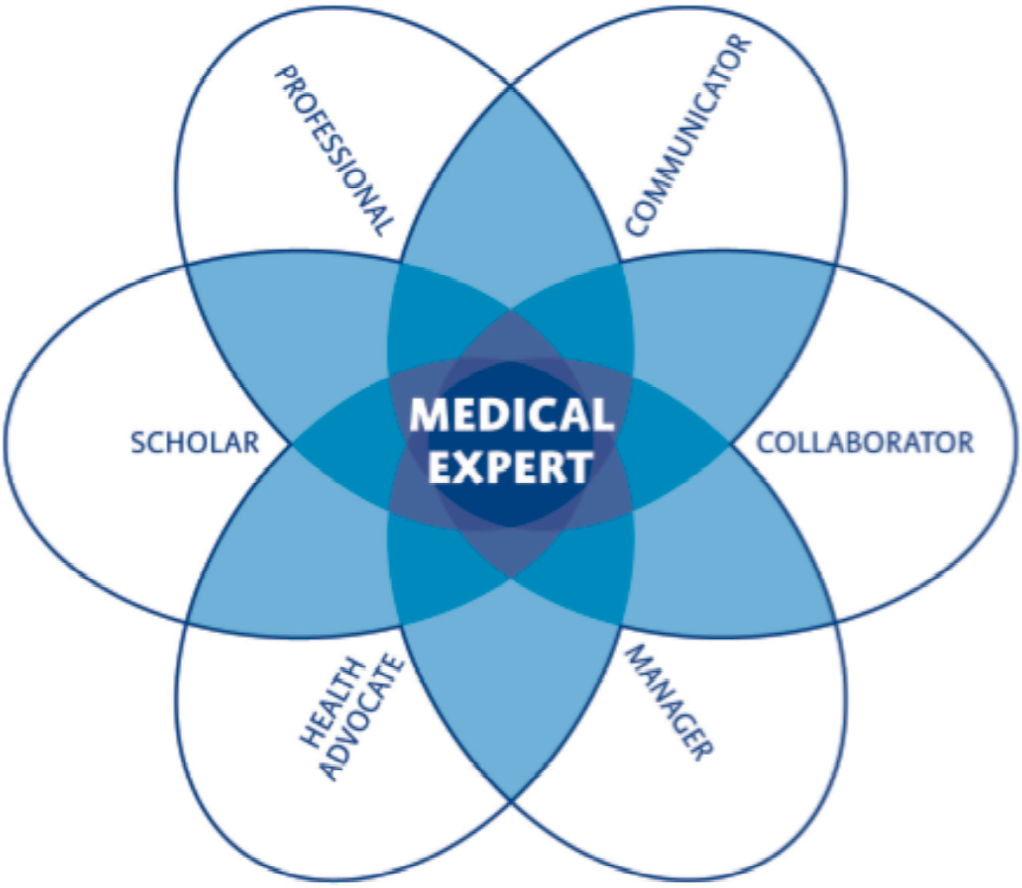
5) Faculties need to particularly address policy surrounding material that directly relates to the trainee's role as a medical professional and/or containing any institutional-identifying content.

Appendix B: Professionalism editorials: Anecdotes offered by students about local professionalism

Listed in Appendix B is limited feedback regarding student perspectives on professionalism. The main concerns cited are social media, attendance, dress code and a question as to what students can and cannot do on their own time.

Appendix C: References

Appendix D: Highlights from literature review



THE CANMEDS ROLES FRAMEWORK

THE MEDICAL EXPERT

Definition

"As Medical Experts, physicians integrate all of the CanMEDS Roles, applying medical knowledge, clinical skills, and professional attitudes in their provision of patient-centered care. Medical Expert is the central physician Role in the CanMEDS framework."

-- CanMEDS 2005 Physician Competency Framework

Professionalism principles

A. Medical students must be aware of the lifelong nature of the information that they are expected to study and solidify as learners. They must demonstrate a commitment, over the course of their careers, to assimilate and operate comfortably with concepts and procedures as outlined by their respective faculties.

B. Medical students will understand the limited scope in which they practice and will operate within these boundaries. If a medical student feels uncomfortable or unsure about their scope of practice, they will communicate their apprehension and clarify their scope with individuals who better understand their limitations of practice before moving forward.

C. Medical students will use their clinical years to adequately transition their theoretical knowledge to more applied, clinical health care practices. Focuses of clerkship years should be development of problem identification, diagnostic reasoning, clinical judgment, decision-making and understanding of applicable therapeutic modalities.

D. Medical student will commit to understanding and practicing basic medical procedure as well as honing skill proficiency during clerk training years.

THE SCHOLAR

Definition

"As Scholars, physicians demonstrate a lifelong commitment to reflective learning, as well as the creation, dissemination, application and translation of medical knowledge."

-- CanMEDS 2005 Physician Competency Framework

Professionalism Principles

A. Medical students must demonstrate a commitment to be aware, through clinical preceptors and self directed research, of new and emerging guidelines and knowledge for clinical care. The proper application of current evidence-based clinical care will allow for higher standards of patient care, better long-term patient outcomes, and proper practice of medicine.

B. Medical students will endeavor to develop critical appraisal skills in order to accumulate their own evidence-based tools and information.

C. As learners, medical students should:

- Attend all mandatory teaching sessions provided for students on campus or at hospital sites in accordance with local faculty policies. Any exceptions should be adequately communicated to and approved by faculty
- Complete all course work, whether mandatory or optional, in a way that will allow them to adequately integrate all relevant clinical information
- Hold themselves responsible for their own learning as well as identify and remedy any knowledge gaps as identified in clinical and classroom settings.
- Seek out and reflect on personal feedback as provided by classmates, preceptors and faculty and constructively use this information to better themselves as practicing clinicians
- Respect all teachers and preceptors as clinicians and individuals
- Respect personal and professional boundaries between faculty and teaching members and the student body so as to engage in only proper professional relationships with teaching and faculty members
- Ensure they can be contacted in order to respond to queries regarding patient care or their own education.

D. Medical students must take an active role in engaging with patients, establishing the therapeutic relationship, and gaining all relevant experience in the clinical setting.

E. All learners and hospital staff should make themselves available for teaching and training of fellow medical learners and colleagues. Honesty and objectivity are of chief importance when assessing the performance of others.

F. Medical students will seek to develop proper research and scientific inquiry methods and ethics.

G. Medical students will be aware of industry influence and perceived influence in the medical profession and will not engage in any activity that could be perceived to affect patient care or student wellbeing. Students will explicitly direct all new industry communications to faculty and have all previously approved industry relations audited by faculty.

H. Medical students have a further responsibility to:

- Demonstrate some teaching skills that are congruent with their level of training. A student should only teach topics with which they are comfortable and that have been reviewed by a senior learner or staff
- Be aware of professionalism guidelines
- Be aware of the process and principles of medical education locally
- Be willing to contribute to the education of others in the medical community
- Give constructive and respectful feedback on the quality of learning and teaching sessions, clinical placements and preceptor performance
- Report any breaches in professionalism, harassment, inappropriate or unprofessional behavior directed toward any student or patient by other members of the health care team.

THE COMMUNICATOR

Definition

"As Communicators, physicians effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter."

-- CanMEDS 2005 Physician Competency Framework

Professionalism Principles

B. Medical students will seek to develop appropriate communication skills that are both accurate and respectful given the clinical situation. Delivery or solicitation of sensitive information (bad news, end-of-life issues, code status, medical error) must be acquired or delivered in an empathetic, respectful, accurate and compassionate fashion.

C. A medical student, like any other member of the health care team, should build relationships with patients based on honesty, trust and good communication skills. All individuals personally related to the patient should also be provided with support when needed and treated with the same care as the patient.

D. Professional boundaries should be kept between the medical student and patient or anyone close to the patient. Any relationship based on anything beyond treatment and management of the patient's condition can be considered unprofessional. The professional position should never be used to cause added distress or for the exploitation of patients.

E. Shall ensure informed consent for every clinical encounter, procedure or discussion that is performed or observed by a medical student. For institutions that are clearly identified as learning centers, implied consent may be assumed for student participation in the patients' care however the student is still responsible to clearly identify themselves as a medical student.

F. For the sake of clarity, the CFMS would advise medical students to refrain from the term *clinical clerk* in favour of the much more widely understood *senior medical student*.

F. Medical students will operate under the premise of full disclosure with the patient at all times. This includes disclosure of medical error or adverse events. Medical students will only offer information that is congruent with their level of training.

G. Medical students are expected to uphold the highest standards of medical confidentiality regarding patient care. A patient's case cannot be discussed

in any way in which they may be identified.

H. Medical students will respect patient diversity in all its aspects at all times. If the student is unable to look beyond the cultural or personal qualities of the patient, they will confer the care of the patient to an individual able to deliver the highest possible quality of care.

I. Medical students will use appropriate verbal and non-verbal communication techniques with all members of the health care team and patient populous.

J. Medical students will commit to learning proper medical documentation for all patients in order to assure the highest quality of care.

K. Medical students will understand that all communications they issue, in the professional or personal setting including on the Internet or in social media, directly reflects on their personal professionalism and also allows for inferences into their medical professionalism.

L. Medical students should dress appropriately and professionally and accept that patients will respond to their appearance, presentation and hygiene.

THE COLLABORATOR

Definition

"As Collaborators, physicians effectively work within a healthcare team to achieve optimal patient care."

-- CanMEDS 2005 Physician Competency Framework

Professionalism Principles

A. Medical students will commit to working effectively and respectfully with other members of the health care team in order to deliver the highest quality standard of care.

B. Medical students will commit to developing skills to work in interdisciplinary teams. These involve respect of skill and contribution of others, and developing effective communication strategies and skills.

C. Medical students will protect patients from harm posed by another colleague's behavior, performance or health. They should take steps to raise concerns to the correct individuals. The local institution or faculty should provide these processes. This should be done in a timely manner to mitigate any undue harm that could be caused to the patient.

D. Medical students should understand the physician's and medical learner's role in the inter- and multidisciplinary team. Furthermore, they should be able to recognize their role and their own limitations within these teams.

E. Medical student will commit to a culture of conflict resolution and prevention in the workplace.

F. Medical students will not engage in any gender, sexual or cultural biases and endeavor to create a positive space in the workplace at all times.

G. Medical students should:

- Develop skills that allow them to thrive in an ever-changing workplace
- Be able to competently work in a team environment and take on different roles when appropriate
- Develop and demonstrate teamwork and leadership skills
- Be aware of the responsibilities of other members of the health care team
- Respect the skills and contributions as well as the diversity of other members of the health care team
- Raise concerns about other health care practitioners if a patient is at risk of harm.

THE PROFESSIONAL

Definition

"As Professionals, physicians are committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behaviour."

-- CanMEDS 2005 Physician Competency Framework

Professionalism principles

A. Medical students will ensure that their behavior, at all times, justifies the trust that the patient and the public place in medical practitioners and the medical profession. Medical students will not only reflect on their behavior but will also reflect on the perception that the public could draw from this behavior and act within the boundaries of public trust. It should be noted that certain behaviours that could be considered unprofessional when conducted in public are not automatically unprofessional in all settings. A behaviour that is unprofessional in public may be completely acceptable with done in a students' private life so long as it does not draw undue attention to the medical community.

B. Are advised to partake in social opportunities that facilitate networking with their colleagues. Immersing oneself in festivities and traditions can be an important method of fostering professional relationships that will aide patient care in the future.

C. Medical students should:

- Readily call attention to errors or concerns about their own clinical work
- Produce academic works that are, in all aspects, their own and will raise issue when there are concerns regarding the honesty of others
- Be honest and trustworthy when recording clinical activities and procedures
- Be honest, respectful and punctual in the completion of teacher, preceptor and class evaluation forms
- Be truthful in their CVs and application, including residency applications, and must not misrepresent their qualification, responsibilities, abilities or publications
- Cooperate in the investigation of any medical, performance, behavioral or health related incidents, whether concerning themselves or any

other members of the health care team

D. When faced with concerns about a colleague's actions, shall first approach the colleague with those concerns (whenever possible). If the colleague cannot satisfactorily appease the concern, then the student shall approach the appropriate authority.

E. Medical students will ensure that they are aware of their own personal health requirements and concerns as well as understand the effect of their own poor health on their ability to provide quality medical care to their patients.

F. Medical students should endeavor to be followed by a GP for regular health care appointments and any continued care.

G. Medical students with particular health concerns and conditions (including psychiatric illness, addiction and substance abuse) will, through the help of anonymous faculty services, seek out specialized care by the most suitably qualified professional. They will also understand that proper management of their condition is essential for adequate patient care.

H. Medical students who are beginning training rotations in culturally unique or foreign locations will attend cultural information and training sessions provided by their faculty.

I. Medical students will commit to understanding the following principles of legal and bioethical practice in Canada as a medical doctor and develop proper practical tools which will ensure that they operate within these guidelines (resource http://www.cmaj.ca/cgi/collection/bioethics_for_clinicians_series)

   a. Consent
   b. Disclosure
   c. Capacity
   d. Voluntariness
   e. Substitute decision-making
   f. Advance care planning
   g. Truth telling
   h. Confidentiality
   i. Research ethics
   j. Euthanasia
   k. End-of-life care
   l. Cultural medicine
   m. Religious interface with medicine
   n. Organ donation

J. Medical students should:

- Be aware of their own medical health concerns that may put colleagues or patients at risk
- Seek medical or occupational health advice if there is a concern about their own health, including psychiatric illness, addiction and substance abuse
- Accept that they may not be able to accurately assess their own health and be willing to be referred for treatment and adhere to any treatment protocols
- Protect their colleagues and patients by being immunized against common communicable diseases as judged appropriated by the faculty of medicine or practicing institution
- Be aware of any communicable infections that they may have and consider the implications of any exposure-prone procedures on the patient. In many cases, the student is encouraged to not perform these procedures and will understand that some limitations can be placed on the scope of practice depending on the medical institution and faculty.
- Will seek advice from a qualified clinician regarding the assessment of risk posed to the patient by their own health
- Be aware of their responsibility to disclose risk to the patient as a result of their health to their faculty and, in further years, their employer.
- Medical students will uphold the highest values of integrity and honesty in their financial dealings. This includes financial obligations that are a requirement of medical education, local society dues, professional society dues, elective and application costs as well as any other personal or professional financial engagement.

THE ADVOCATE

Definition

"As Health Advocates, physicians responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations."

-- CanMEDS 2005 Physician Competency Framework

Professionalism Principles

A. Medical students will remain, before any other role, advocates for appropriate high quality patient care and the highest standards of patient safety. They will understand their fiduciary duty as medical trainees to this principle.

B. Medical students will develop skills and modalities that will help the learner in present and future advocacy and initiatives of population and community health.

C. Medical students will understand the influence and authority of their role in the patient's eyes. The medical student will make responsible use of this real or perceived influence/authority in the student-patient relationship.

THE MANAGER

Definition

"As Managers, physicians are integral participants in healthcare organizations, organizing sustainable practices, making decisions about allocating resources, and contributing to the effectiveness of the healthcare system."

-- CanMEDS 2005 Physician Competency Framework

Professionalism Principles

A. Medical student will take an active role in the clinical setting.

B. Medical students will commit to the concept of shared decision making with all members of the health care team as well as the patient and their family.

C. Medical students will not conduct independent decision-making in the treatment course of a patient without senior qualified clinical approval.

D. Medical students are often the most visible and accessible part of the health care team to patients. Student must realize that patients often feel as though students are in a position of responsibility when it comes to their care. The medical student's personal opinion and all communications to the patient must be weighed in this light.

Appendix A -- Digital media and medical professionalism

In discussing with members of the CFMS executive, members of the membership and through literature review in the field of digital media and professionalism, it has become abundantly clear that the Canadian medical community has little infrastructure and policy surrounding this issue. This is by no means a fate strictly Canadian. It is easy to find a steady stream of literature reporting parallel issues in the international community. Policy is not the only barrier to digital professionalism.

Literature and experience also demonstrate that the understanding of digital media systems by faculty administration is limited at best. There is little understanding of the possibilities, scope, reach and utility of digital media systems nor is there the ability to distinguish between different vectors of social and digital media. This is particularly concerning since these are the administrative structures that manage breaches, real or perceived, of professionalism by students.

Thirdly, and maybe more importantly, those using digital media often experience an important blurring of personal and professional lives, believing that their online presence has little to no link to their professional life. Furthermore, there is little understanding of the reach of these digital media modalities and their truly public nature. In a world where most individuals communicate with audiences of 100 or more acquaintances, there is little argument against the public nature of these media. Opinions, comments, photos and activities while on social media contribute to the public image of both oneself as a future medical practitioner, one's faculty as the training institution and the profession of medicine. The definition of public must therefore change in a way that would include the public nature of online media.

As identified in *Commentary*: *The Relationship Status of Digital Media and Professionalism: It's Complicated*,

> Professionalism, appropriateness for public consumption, and individual or institutional representation in digital media content are just some of the salient issues that arise when considering the ramifications of trainees' digital behavior in the absence of established policies or education on risk.[...] The positive implications that Web-based applications share (e.g., flexibility, collaboration, and interactivity) must be weighed against the negative implications, including potential misuse, violations of confidentiality, and threats to professionalism.[1]

Furthermore, the commentary highlights important questions surrounding patient-student relationships online.

> As patients become increasingly web savvy, they are experiencing an

> entirely new accessibility to their physicians. There have been reports of patients attempting to "friend" their physicians on social networking sites, such as Facebook and MySpace, and also posting public messages regarding their satisfaction, or dissatisfaction, with their physician performance. Questionable "friendings" between patients and physicians, or even physicians at varying levels of training (e.g., residents and attendings), are occurring with alarming frequency.[2]

The interest lies in the right of the profession and its institutions to step into the medical student's and practitioner's personal life. It is each Canadian's constitutional right to freely express their views. But where does one draw the line between over-infringement and proper management of medical professionalism? The reality is that there is no real answer to this question. It could be argued, quite convincingly, that citing a medical student or practitioner for unprofessional conduct does little in the way of impeding the individual's rights, though it can sharply affect the medical student's career. For this reason, clear and understood policies surrounding medical professionalism in digital media must exist and must be agreed upon by all students when beginning their medical education.

More importantly, online professionalism needs to be taught and clearly communicated with a written transparent document provided by the training faculty. With case scenarios, infringements on professionalism can be weighed by the students. A proper mechanism for objection to items in the local professionalism charter should be in place. The faculty should be in a place to defend each professionalism principle with a lessons-learned or an evidence-based approach. Alternatively, the faculty is encouraged to appoint a student committee to be part of the professionalism charter drafting whereby policies are drafted and accepted by students.

Institutions have further incentive for establishing clear guidelines for professionalism and policies on campus. Through the use of online digital video media, medical students continue to have an increased presence online.

> In addition to representing an individual's viewpoint, digital media postings may contain subliminal content, such as the use of a school name, property, or logos, which may be misconstrued as implicit institutional endorsement of the content of the information.[3]

Students must be aware that this is a realistic probability, especially when considering the audience to which these productions are intended. Not all members of the public understand the intricacies and nuances in the relationship between faculty and students, therefore misconstruing the student's view for those of the mother institution.

And lastly, the effect of such digital material and its lasting nature online leaves a

behavioral and professional snapshot of the student on the web for years to come. Students must understand the impression they leave on the web and on prospective residency directors, attending staff, health care coworkers and patients in the future and become familiar with the repercussions this may have. The CFMS recommends the following as appropriate steps in addressing professionalism in digital media:

1) Training institutions should commit to establishing familiarity amongst faculty of digital media. They will provide exposure and training, which could be led or demonstrated in part by the student body, to all faculty members that are in a position to rule on the professionalism of students, to those who are interested and to the senior leadership of the faculty. This will allow for a more positive space and discussion surrounding digital media, will allow the faculty to develop socially appropriate policies of professionalism and will allow a stronger monitoring of online professionalism.

2) Students and faculty should come together to jointly draft online professionalism policies to be followed at their local campus. Through these sessions, both partners will work together and draft case scenarios which will later help to train the larger student body on medical professionalism. This will help students understand the potential risk of their behavior. Education is likely the best approach to solving and preventing breaches of professionalism online. This should also include policy to help institutions protect their own identity as well as protect the identity and public perception of the profession. It is best stated in saying: "Trainees must realize and acknowledge that the digital intersection of their personal and professional lives can be blurred in light of the medical profession's accountability to society." [4]

3) These parties should also develop digital media professionalism curricula for all students through whichever education vector deemed appropriate, digital or otherwise.

4) The CFMS recommends that all medical students subscribe to online services which will provide notices any time their name is published online. Continuous monitoring of material posted without one's consent and of one's online identity is essential to preserving professionalism. This is easily done through Google Alerts online service.

5) Faculties need to particularly address policy surrounding material that directly relates to the trainee's role as a medical professional and/or containing any institutional-identifying content.

Appendix B --Professionalism editorials: Anecdotes offered by students about local professionalism

1) Does your university have a medical professionalism policy and if so, are students aware or trained on its content?
    - Yes. Students are aware of the professionalism policy but students are not adequately trained in its content.
    - A faculty policy is currently being developed and is in the Draft stage. Students were directly consulted for a major portion of the document's development, and it is expected that there will be a formal presentation to students once it is completed and approved
    - In conjunction with faculty (Dean of Student Affairs & Dean of Professionalism and Equity) I drafted a document, now available on our school website, regarding medical student professionalism. I believe students are informed of its content.

2) What are the perceived major professionalism issues at your school?
    - Social Event conduct (dress code, drinking, destructive behavior)
    - Low attendance
    - Dress Code
    - Social media (and lack of guidelines)
    - Nothing specific. Some students seem to underestimate the professionalism expectations of medical students. This leads to low attendance in some sessions, tardiness, etc
    - Inappropriate posting of patient information/pictures on social networking sites as well as off color comments on similar sites

3) Are there major incidents of medical professionalism that have required attention in specific areas of medical professionalism? What are these areas of concern?
    - Disclosure of patient details in conversation or social media is infrequent but a serious problem that we are hoping to prevent going forward

4) Are faculties addressing these areas of concern and, if so, how?
    - Pop assignments in class to address low attendance
    - Based on the direct consultation and recommendation of students, have allowed for student-led professionalism sessions to go forward. The pilot session was well received last fall and we will be organizing two formal sessions this fall
    - Medical student professionalism document. Evaluation of individuals via numerous interviews, peers and faculty.

5) Do you feel as though medical professionalism concerns, in general, are dealt with in a clear, transparent and consistent way?

- Generally dealt with on an individual basis. No clear policy but no public concerns regarding how professionalism issues are handled.
- Increasingly so. The student policy, in conjunction with the faculty policy, should ensure the process is far more transparent going forward.
- Overall the dean of professionalism and equity at our school is NOT well known. Students are generally not aware of this resource, and indeed unaware that the admin would like students to report issues they observe regarding professionalism.

6) What are the anticipated issues at your school when considering medical student professionalism in the coming years?
   - Increasing use of social media. Concerns over the lack of appropriate mechanisms to identify and remediate problematic students.
   - Most likely digital media issues and appropriate use of the internet. I imagine all professionalism issues will revolve around the grey area of what can and can not you do on your own time.

7) In your opinion, does your faculty have an official position/policy regarding student behavior on social media? Are faculty expectations and professionalism limitations clear?
   - No, we are referred to the general professionalism document, but it does not specify any social media examples.
   - No, not yet. This is in the process of being addressed
   - Faculty has adopted the student generated document on social media. Expectations, in my opinion, could be made more explicit.

8) Do you feel as though your faculty is knowledgeable enough in social media to make a fair and transparent policy?
   - Probably, but they will likely ask students for their input as well.
   - The faculty has consulted students to help develop the social media policy to ensure that this is relevant and equitable.
   - Probably not.

Appendix C -- References

Appendix A quotations (1), (2), (3) and (4) from
Commentary: **The Relationship Status of Digital Media and Professionalism: It's Complicated**
by J. Farnan, J. Paro, J. Higa, S. Reddy, H. Humphrey and V. Arora

Appendix D – Highlights from literature review

Commentary: **The Relationship Status of Digital Media and Professionalism: It's Complicated**
by J. Farnan, J. Paro, J. Higa, S. Reddy, H. Humphrey and V. Arora

"Despite the increased popularity and use of such applications amongst the current generation of trainees, medical educators have little evidence or guidance about preventing misuse and ensuring standards for professional conduct. As trainees become more technologically savvy, it is the responsibility of medical educators to familiarize themselves with the advantages of this technology but also with the potential negative effects of its misuse." Acad Med. 2009; 84:1479-148.

"Professionalism, appropriateness for public consumption, and individual or institutional representation in digital media content are just some of the salient issues that arise when considering the ramifications of trainees' digital behavior in the absence of established policies or education on risk." Acad Med. 2009; 84:1479-1481.

"The positive implications that Web-based applications share (e.g., flexibility, collaboration, and interactivity) must be weighed against the negative implications, including potential misuse, violations of confidentiality, and threats to professionalism." Acad Med. November 2009; 84: 1479-1481.

"The issues of professionalism and digital media must be considered within the appropriate context. Is digital content posted by trainees the personal behavior of an individual who happens to be a medical trainee, or of an individual in the role of a medical trainee? … however, there are an increasing number of in vivo medical training postings, students and trainees posting material while in their roles as health care providers."

"Social networking tools, when used in a professional manner, may help to address, not create, communications barriers."

"As patients become increasingly web savvy, they are experiencing an entirely new accessibility to their physicians. There have been reports of patients attempting to "friend" their physicians on social networking sites, such as Facebook and MySpace, and also posting public messages regarding their satisfaction, or dissatisfaction, with their physician performance. Questionable "friendings" between patients and physicians, or even physicians at varying levels of training (e.g., residents and attendings), are occurring with alarming frequency."

"Regulation must, however, be tempered by sensitivity to students' rights to free speech."

"… "students in school, as well as out of school, are 'persons' under our Constitution [and] are entitled to freedom of expression of their views." An important caveat and precedent established by this ruling was the "material disruption" clause, which states that any conduct that "materially disrupts class work or involves substantial disorder or invasion of the rights of others is not immunized by the constitutional guarantee of freedom of speech."

"In addition to representing an individual's viewpoint, digital media postings may contain subliminal content, such as the use of a school name, property, or logos, which may be misconstrued as implicit institutional endorsement of the content of the information."

"Finally, trainees may personally experience repercussions of their behavior, as prospective employers, such as residency directors, colleagues, and patients, have open access to potentially compromising depictions of the trainees on publicly available sites."

"Establishing faculty familiarity with theses applications and their capabilities is a logical first step in an effort to educate about and patrol for negative material. Ensuring students' understanding of the potential risk of their behavior is also essential. Education on the ramifications of posting negative material is likely a more effective approach than instituting blanket institutional policy aimed at strictly regulating trainees' online contributions. Providing trainees with commonsense suggestions for preserving a professional "digital image," such as maintaining strict privacy settings on social networking sites and espousing a "think-before-you-post" attitude, are simple initial steps. We encourage our trainees to routinely perform searches for their names online and to identify material posted without their consent. These solutions are the first steps in protecting trainees' "digital reputations."."

"Educators must also develop and enforce policy aimed at protecting the representation of both their institution and the medical profession. Trainees must realize and acknowledge that the digital intersection of their personal and professional lives can be blurred in light of the medical profession's accountability to society."

"As a result of our personal experience, we have developed a policy which requires that material occurring in the context of the individual's role as a medical trainee, or containing institution-identifying content, be reviewed by faculty for appropriateness before posting."

"Answering such questions as whom to "friend" on social networking sites and what constitutes inappropriate contact between a trainee and a patient, colleague, or superior are a few of the issues we have addressed in a "Medical Professionalism in the 21st Century" curriculum implemented this past fall."

“Ultimately, we must impart to students the primary importance of “connectivity,” maintaining a dynamic of trust and respect between doctor and patient.”

Attributes of a good physician –Journal of Medical Ethics, 2010; 36:121-125
by M. Sehiralti, A. Akpinar and N. Ersoy

“ 54.6 % of students were concerned with interpersonal relations and communication, whereas the category representing the fewest attributes (12.3%) was that involving scientific knowledge and medical practice. In general, students’ perception corresponded to the concept of the ‘competent physician’ as described in the professionalism projects, but attributes reflecting their world-view were also expressed.”

“For instance, professionalism is one of the six general competencies in the Accreditation Council for Graduate Medical Education (ACGME) outcome project. The residents are expected to display compassion, integrity, respect, responsiveness, accountability and sensitivity if they are to fulfill the competency of professionalism.”

“The medical school objectives project of the Association of American Medical Colleges (AAMC) determined four attributes expected from students that should be practiced adequately by the time a student graduates. Apart from altruism, the three sections of the Turkish CMC corresponded to the attributes of being knowledgeable, skilful and dutiful, which are also specified by the AAMC.”

“However, teaching professionalism cannot be left to the implicit curriculum that works through respected role models, and there is an increasing emphasis in the literature on the importance of including it as a topic within the formal curriculum.”

“In addition, despite the increased interest in teaching professional attitudes and communication skills, there is little interest in the subject of developing medical professionalism in students, and only a small number of studies have been carried out in this area.”

“If students can be educated in ways that sustain and enhance their values, and in particular foster the concept they already possess (at the beginning of their first year) of an ‘ideal physician’ who will meet the expectations of the patients they are preparing to serve professionally, this will contribute significantly to their development as good physicians. Equally, it is important that the curriculum include opportunities to identify and acquire any appropriate attributes in which they are lacking.”

Impact of peer assessment on professionalism – Academic medicine Jan 2010; 85: 140-147.
by A. Nofzinger, E. Naumburg, B. Davis, C. Mooney and R. Epstein

Peer assessment form is included in the report.

"Many (67%) found peer assessment helpful, reassuring, or confirming of something they knew; 65% reported important transformations in awareness, attitudes, or behaviors because of peer assessment. Change was more likely when feedback was specific and described an area for improvement. Wholly negative responses to peer assessment process were rare."

"It is not clear how professionalism should be assessed or whether feedback about professional behaviors improves future performance."

"Peer assessment has been recommended as one way to measure and promote professionalism, as medical trainees know each other well and make close observations of their classmates' work in a variety of contexts. The exercise of providing clear, helpful feedback to peers is itself training in professionalism."

"Students view the reluctance of teachers to confront a student about unprofessional behavior as a significant obstacle to effective evaluation of professional behaviors."

Review: Incorporation professionalism into Medical Education: The Mayo Clinic Experience
by Paul S. Mueller

"One definition of profession is "a calling requiring specialized knowledge and often long and intensive preparation including instruction in skills and methods as well as in the scientific, historical, or scholarly principles underlying such skills and methods, maintaining by force of organization or concerted opinion high standards of achievement and conduct, and committing its members to continued study and a kind of work which had for its prime purpose the rendering of a public service.""

"Notably, professional societies have used similar approaches to defining professionalism (i.e., these definitions typically include lists of attributes of professionalism). […] [W]hat is remarkable is that the various approaches generally list similar sets of attributes of professionalism."

"In contrast, physicians possess specialized and highly complex knowledge and skills, prescribing rights, and other powers that patients do not have. Patients who are ill or injured (and, hence, vulnerable) must therefore trust that the physician is acting on the patient's behalf."

“With the attributes of professionalism and physicians’ fiduciary duties in mind, society’s expectations of the medical profession can be listed: competence, the services of the healer, altruism, integrity, transparency, and accountability, and promotion of the public good. One can also list the profession’s expectations of society: autonomy (i.e., to train, admit, monitor, discipline, and expel its members), a functioning healthcare system, and sufficient resources to meet its responsibilities.”

Table 3 Reasons for teaching and assessing professionalism

1.	Teaching and assessing professionalism does not occur by chance alone.
2.	Patients expect physicians to be professional.
3.	Medical professional societies expect professionalism to be taught and assessed.
4.	Professionalism is associated with improved medical outcomes.
5.	Unprofessional behavior is associated with adverse medical outcomes.
6.	Accreditation organizations require that professionalism be taught and assessed.
7.	Professionalism can be taught and learned.
8.	Professionalism can be assessed.

“In order for medical students and physicians in training to become professionals and physicians in practice to remain professionals, the elements of the framework of professionalism […] should be intentionally taught. […] Likewise, professionalism should be intentionally assessed. Clear expectations and rich experiences alone will not guarantee that professionalism is learned. Assessment motivates individuals to learn what is important (i.e., professionalism) and helps determine whether competency in professionalism has been achieved.”

“In one study, 192 patients were asked to describe ideal physician behaviors. Seven behaviors were identified: being confident, empathetic (“understands my feelings”), humane (compassionate and kind), personal (i.e., viewing the patient as a person rather than a disease), forthright (“tells me what I need to know”), respectful, and thorough. Indeed, in another study, compassionate care was the factor that most predicted patient willingness to return for or recommend (to others) care in the outpatient setting, whereas delivery of care (especially that which encouraged patients to ask questions) and compassionate care were the factors that most predicted willingness to return for or recommend care in the inpatient setting.”

“An important reason for teaching and assessing professionalism is that professionalism is associated with improved medical outcomes including increased patient satisfaction and trust, increased patient adherence with treatments, increased likelihood patients will stay with a physician, fewer patient complaints, and less patient litigation. In addition, professionalism is associated

with overall physician excellence including medical knowledge, skills and conscientious behaviors."

"In a survey of 1,627 physician executives, more than 95% reported that they regularly encountered unprofessional physician behaviors including disrespect, yelling, insults, abuse, and refusal to complete duties. These behaviors involved nurses, other physicians, administrators, and patients."

"Notably, if unprofessional behaviors are not addressed, learners may come to regard such behaviors as acceptable and incorporate the behaviors themselves."

"One study[28] found that physicians disciplined by the California state medical board had significantly higher odds of having manifested unprofessional behavior (e.g., poor reliability and responsibility, lack of self-improvement and adaptability, and poor initiative and motivation) during medical school than non-disciplined physicians. A larger study[29] involving 40 U.S. state medical boards had similar findings."

"Overall, assessments should be used to enhance professionalism in all learners and practicing physicians, reward exemplars, identify those with lapses in professionalism, and dismiss those who cannot achieve this core competency."

"How does one teach professionalism? One can start by teaching the foundational elements of professionalism: clinical competence, communication skills, and an understanding of the legal and ethical aspects of medicine."

"In addition to teaching foundational elements of professionalism, the attributes of professionalism -- excellence, humanism, accountability and altruism should also be taught in order to foster the development of the complete and professional physician."

"However, using interactive teaching methods such as case discussions and hands-on practice sessions can improve learner performance and patient outcomes. Therefore, teaching and learning professionalism may be better achieved by using interactive methods such as discussion groups (e.g., the "challenging case"), role play, simulation using actor-patients, and team learning."

"First, a culture of humanism should be established; doing so conveys a message that the desire to teach professionalism is authentic. Second, the curriculum should be practical and relevant; learners will be most engaged in learning professionalism when it is taught in the context of their field of study […]. Third, learners should be engaged in tasks that challenge and grow communication […]. Professionalism lapses, communication failures, and similar events should be recognized and used for formative feedback and teaching. [...] Fourth, self-reflection should be encouraged […]. Indeed, "critical incident

reports," short narratives written by medical students and physicians that describe meaningful moments in clinical practice, can be an effective tool for teaching professionalism, especially if coupled with group discussion and reflection. Fifth, the "hidden curriculum" should be intentionally addressed particularly if it is at odds with the formal curriculum related to professionalism. Not addressing the "hidden curriculum" conveys the message that what is taught is not necessarily what is practiced […] Finally, negative role-models and "disruptive" physician educators (e.g., those who abuse learners) should be identified, provided feedback regarding their behaviors, offered remediation, and, if necessary, dismissed from teaching."

Table 4 Methods of teaching and approached to assessing professionalism

Methods of teaching professionalism
1. Didactic lectures. 2. Web-based curriculum. 3. Discussion groups. 4. Role-play. 5. Simulation using patient-actors. 6. Team learning. 7. Role-modeling with discussion and reflection.
Approaches to assessing professionalism
1. Commence at the start, and continue throughout, the learner's career. 2. All levels of the hierarchy (i.e., medical students, physicians in training and physicians in practice) should be assessed. 3. Individuals should know they are being assessed. 4. Use multiple assessment tools and observers. a. Tests of knowledge, skills (e.g., communication skills), and reasoning (e.g., ethical dilemmas). b. 360-degree reviews by faculty attendings, peers, allied healthcare staff (e.g., nurses), and others. c. Objective structured clinical examination. d. Patient assessments. e. Critical incident reports. 5. Use for formative and summative feedback; professionalism "portfolio." 6. Use for assessing professionalism education programs and conducting professionalism research.

Assessment of matriculating medical students' knowledge and attitudes towards professionalism – Medical teacher 2009; 31: 928-932
By A. Blue, S. Crandall, G. Nowacek, R. Leucht, S. Chauvin and H. Swick.

"Results indicate students' attitudes are positive about several of the attributes associated with traditional professionalism definitions; however, there were cases where students' knowledge and attitudes towards professionalism appear incongruent with traditional definitions. Further development of self-assessments of knowledge and attitudes towards professionalism are suggested."

"Professionalism is a complex attribute to assess, and several authors have rightly argued that assessment needs to address contextual and environmental features associated with professional behaviour (or lack thereof), (Ginsburg et al. 2000; Arnold 2002) as well as students' perceptions, reasoning, motivations, and attitudes related to professionalism (Lingard et al. 2001; Ginsburg et al. 2003, 2004; Rees & Knight 2007)."

"Of Swick's attributes of professionalism, five have face validity for being reasonable expectations for medical student behaviour.
The five dimensions are:
(1) subordinate one's self-interest to the interest of others ('Subordinating Self-interest');
(2) adhere to high ethical and moral standards ('Ethics and Moral Values');
(3) evince core humanistic values, including honesty and integrity, caring and compassion, altruism and empathy, respect for others and trustworthiness ('Humanistic Values');
(4) exercise accountability for oneself and for others ('Accountability');
(5) incorporate self-reflection about one's actions and decisions ('Self-reflection')."

"One instrument, the semantic differential, asked students to rate the five attributes of professionalism as a stimulus word on 7-point, seven bipolar adjective scales (good–bad; fast–slow; small–large; pleasant–unpleasant; active–passive; awful–nice; light–heavy)."

"One knowledge instrument, the Medical Vignettes, presented students with 15 vignettes each reflecting one of the five attributes of professionalism."

"Understanding students' knowledge and attitudes towards professionalism is an important step in understanding why certain behaviours may be more likely to occur, and why in particular contexts. Furthermore, understanding students' knowledge and attitudes towards professionalism can direct instructional efforts where they are most needed."

"The results of this study indicate that students enter medical school with positive attitudes towards professionalism attributes, but that they do not necessarily know how these attributes function in practice. They appear to have the greatest knowledge of humanism and professional responsibility and hold the most positive attitude towards humanistic and ethical and moral values. Knowledge of professional commitment and managing complexity and uncertainty as a professionalism attribute appear less clear for students. The concept of subordinating self-interest appears less meaningful for students as a professional attribute as well."

"Osborn (2000), in her story about a medical student cheating incident, notes a large disparity between students and faculty perceptions of cheating. To what extent our results, as well as those of others, reflect real generational differences is an area for further research."

Learning Professionalism: Perspectives of Preclinical Medical Students – Academic Medicine, Vol. 84, No. 5 / May 2009
By A. Baernstein, A. Amies Oelschlager, T. Chang and M. Wenrich

“Medical schools should ensure that students are exposed to excellent role models—ideally, faculty who can articulate the ideals of professionalism and work with students longitudinally in clinical settings. Lectures about professionalism may alienate rather than inspire students. Students’ premedical experiences and values influencing professionalism should be acknowledged and appreciated. Bedside teaching and reflection on students’ inner experience as they begin to work directly with patients deserve further exploration as opportunities to teach professionalism.”

“Students receive an explicit set of behavioral expectations called professionalism benchmarks. All second-year students must complete and pass a six station objective structured clinical examination (OSCE) before progressing to clerkships. One OSCE station specifically addresses a professionalism issue.”

Table 1

The Formal Curriculum in Professionalism for Preclinical Students, University of Washington School of Medicine, 2003–2004 and 2004–2005

Preclinical year	Lectures/panels*	Small-group discussions†	Written reflections‡	Ceremony	Evaluation
First year	• Adjustment to demands and privileges of being a medical student • Confidentiality • Conflict between professional responsibilities and personal values • Meaning of the doctor–patient relationship • Narrative medicine • Physicians in film and literature • Sensitivity and caring • Sexuality/sexual minorities • Substance abuse	• Delivering bad news • Empathy • Hopes and fears of a career in medicine • Sexuality/sexual minorities • Substance abuse • Peer advising: first-through fourth-year students who share a college mentor meet for one hour on a quarterly basis to share information and advice	• Continuity of care	• Stethoscope presentation at orientation • White coat ceremony (some regional sites only)	• Review of videotaped interview (once) • Written evaluation by small-group leader (quarterly)
Second year	• Caring for patients with life-threatening and terminal illness • Culture and medicine • Medicine and the law • Motivational interviewing • Physician impairment • Uncertainty and mistakes in medicine	• Conflict between professional responsibilities and personal values • Racial disparities in medical care • Peer advising: described above	• Caring for patients with life-threatening and terminal illness • Sexuality/sexual minorities • Substance abuse/Alcoholics Anonymous or Narcotics Anonymous visit	• Clinical transition ceremony at end of year	• Objective structured clinical exam • Written evaluation and in-person individual feedback by college mentor (quarterly)

* These large-group sessions vary in length from one to three hours.
† Listed topics are those with scheduled small-group discussions. Small groups are also encouraged to discuss all topics from lectures and panels and to address professional issues that arise while working with patients. Second-year small groups are facilitated by college mentors. Most discussions are scheduled for one hour.
‡ Written reflections are one to two pages in length. They are responses to open-ended questions. There is no formal scoring system. They are reviewed by the student’s college mentor, who makes written comments shared privately with the student.

“We identified four domains as most salient for students: “observing what is professional” (role models), “being told what is professional” (formal curriculum), “what I bring to medical school” (prior life experience or background), and “learning on the job” (experiential learning). Mean interrater agreement on domains and categories within domains was 94% (range 89%– 100%, SD 3.66), and mean kappa value was 0.84 (range 0.73–1.0, SD 0.09), indicating excellent reliability.”

“Ideally, students would have a long-term relationship with a faculty member to facilitate trust and awareness of the student’s developmental process. Peers are also an important and underemphasized source of learning; therefore, professionalism should be a focus at admissions and in clinical evaluations, and peer-group discussions and bedside rounds should be used for teaching. In regard to the formal curriculum, talking about professionalism seems most likely

to be effective when tied to the student's own experiences and observations, both prior to medical school and from the student's earliest patient contacts."

Medical Students' Professionalism Narratives: A Window into Informal and Hidden curriculum – Acad Med 2010; 85:124-133.
by O. Karnieli-Miller, T.R. Vu, M. Holtman, S. Clyman and T. Inui

"The findings strongly suggest that students' reflective narratives are a rich source of information about the elements of both the informal and hidden curricula, in which medical students learn to become physicians. Experiences with both positive and negative behaviors shaped the students' perceptions of the profession and its values. In particular, interactions that manifest respect and other qualities of good communication with patients, families, and colleagues taught powerfully."

"…students' experiences in the environment of the academic health center or other clinical venues are the most powerful determinants of future physicians' perceptions of what pass for acceptable behaviors and values in the practice of medicine."

"The hidden curriculum is the physical and workforce organizational infrastructure in the academic health center that influences the learning process and the socialization to professional norms and rituals. The informal curriculum is the student's immersion in the interpersonal processes in the academic health center, including interactions between students and their teachers, interactions among the interprofessional participants in medical care processes, and interactions that students experience with patients and their family members."

"…the hidden and informal curricula are rife with events and experiences that students see as "teaching them something about professionalism and professional values.""

Predicting failing performance on standardized patient clinical performance examination: The Importance of Communication and Professionalism Skills Deficits – Acad Med 2009; 84:Issue 10 ppS101-S104
by A. Chang, C. Boscardin, C. Chou, H. Loeser and K. Hauer.

"Performance concerns in communication and professionalism identify students at risk of failing the patient-physician interaction portion of a CPX. This correlation suggests that standardized patients can detect noncognitive traits predictive of failing performance. Early identification of these students may allow for development of a structured supplemental curriculum opportunities for practice and feedback. The lack of predictors in the clinical skills portion suggests limited faculty observation or feedback."

Professionalism beyond medical school: An educational continuum? – EJIM 2009; 20: e148-e152.

“Despite differences in definition, professional values common to the undergraduate medical curricula are altruism, respect for others, and additional humanistic qualities such as honour, integrity, ethical and moral standards, accountability, excellence and duty/advocacy [1,2].”

“Recent landmark studies provide evidence that (un)professional behaviour strongly interlinks across the different training phases. Unprofessional behaviour during medical school may lead to subsequent problems as a physician. Persistent irresponsibility during medical training has been associated with a higher risk of disciplinary action as a physician [15–17].”

“A study of internal medicine residents reported that 6 of 8 residents who received a warning or probation had been in the bottom 20% resident ratings for professionalism [19].”

“Scores given residents by staff and peers for interpersonal skills, communication and professionalism competency correlated significantly with their medical knowledge scores [20]. Anaesthesia residents with unprofessional behaviour tended to have problems with clinical performance as well [21].”

“The contemporary clinical environment with high patient volumes and low staff-to-patient ratios can impact negatively on professional behaviour, fostering an attitude among residents that their job is to “get rid of patients” [14,40].”

“As duty hour changes mainly concern residents, reductions in residents' duty hours, have negatively impacted on the development of professional behaviour. In a US study, a large group of internal medicine, neurology and family practice residents felt that time pressure and constraints (including duty hour requirements) prevented the incorporation of professionalism into daily practice [45]. A possible explanation is insufficient time to develop a trusting relationship with patients [46].”

“The duty hour changes aim to promote resident well-being, reflection, and teamwork [44,45]; important aspects of professionalism.”

“The so-called teaching “between the blackboard and the pen”, learning via “the corridor” [52], or “hidden” or “informal” curriculum impacts more on residents and students in the clinical rather than the pre-clinical phases. It provides a key opportunity to cultivate professionalism and has been shown to influence and aid in the development of professional values, attitudes and behaviour [53].”

“In other words, everyone agrees that professionalism training in residency is essential [67], but there is little consensus on how to achieve this.”

“It is self-evident that focusing informal teaching and assessment alone is not enough. As previously noted, faculty development programmes aimed at improvement of role modeling should also be instituted.”

Professionalism in Medicine: We Should Set the Standard – Military medicine 174; 8:807, 2009.
by Col M. C Nace, Col. S. Dunlow and Col A. Armstrong.

“Problems with professionalism are not new, nor are they abundant in our profession. However, hopefully a renewed focus on professionalism early in one's medical training will eliminate escalation of unprofessional behavior throughout an individual's career.”

“The ACGME* defines professionalism as "manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.""

“The most common methods of identification of problems with professionalism are: direct observation (84%), critical incidents (59%), poor performance at conferences and rounds (45%), and neglecting patient care (33%).”

“Yao et al. found that the individuals most likely to identify problems of professionalism among residents were: chief residents (84%), attending physicians (76%), program directors (74%), other residents (49%), and nursing staff (31 %). Interestingly, patients and family identified these problems in only 2% of the cases.”

“Unfortunately, professional values can be difficult to measure and even more difficult to freely discuss with individuals without having them feel threatened or imply they have a character flaw. […] For example, instead of accusing a resident of being irresponsible (which may provoke an argument), discuss the exact problem that occurred and how it impacted patient care (not knowing an abnormal laboratory result did not allow for timely management of the patient's disease).”

“Sixty percent of program directors strongly agreed or agreed that a lack of accurate, honest, written evaluations of residents contributed to the difficulty in convincing problem residents of their deficiencies.”

“The issue of litigation surrounding problem residents is not new. Forty-nine percent of the program directors surveyed in Yao's article acknowledged threats of litigation from dealing with problem residents and 15% had been in actual lawsuits regarding problem residents.”

"The methods that they have used to address these problems include: expression of expectation of improvement (95%), psychological counseling (68%), placing the resident on probation (59%), and dismissal (30%). Clearly, the approach used needs to best fit the problem that has been identified in the resident."

TABLE I. Resources (http://www.acgme.org/acWebsite/home/home.asp)

Identification	www.acgme.org/outcome/comp/refs References on Medical Professionalism
Documentation	Cohen JJ. Measuring professionalism: listening to our students. Acad Med 1999; 74: 1010.
Training	Advancing Education in Medical Professionalism http://www.acgme.org/outcome/implement/Profm_resource.pdf ACGME Outcomes Project (outcomes@acgme.org)
Remediation	Osborn E. Punishment: a story for medical educators. Acad Med 2000; 75: 241-4.

Online posting of Unprofessional Content by Medical Students – JAMA. 2009;302(12):1309-1315.
By K. Chretien, S. Greysen and J-P. Chretien

"Of these schools, 60% (47/78) reported incidents of students posting unprofessional online content. Violations of patient confidentiality were reported by 13%(6/46). Student use of profanity (52%; 22/42), frankly discriminatory language (48%; 19/40), depiction of intoxication (39%; 17/44), and sexually suggestive material (38%; 16/42) were commonly reported. Of 45 schools that reported an incident and responded to the question about disciplinary actions, 30 gave informal warning (67%) and 3 reported student dismissal (7%). Policies that cover student-posted online content were reported by 38% (28/73) of deans. Of schools without such policies, 11% (5/46) were actively developing new policies to cover online content. Deans reporting incidents were significantly more likely to report having such a policy (51% vs 18%; P=.006), believing these issues could be effectively addressed (91%vs 63%; P=.003), and having higher levels of concern (P=.02)."

"An estimated 75% of US adults aged 18 to 24 years who use the Internet and 57% aged 25 to 34 years use social networking sites."

"Web 2.0 also risks broadcasting unprofessional content online that can reflect poorly on individuals, affiliated institutions, and the medical profession. […]

However, the social contract between medicine and society expects physicians to embody altruism, integrity, and trustworthiness. Furthermore, ethical and legal obligations to maintain patient confidentiality have unique repercussions. Yet, defining unprofessionalism online is challenging; there are no formal guidelines for physicians."

"Most respondents reported never or rarely using social networking sites (68%; 48/71), reading blogs (79%; 56/71), posting on blogs (87%; 61/70), reading wikis (69%; 48/70), or writing on wikis (91%; 64/70)."

"Incidents involving violation of patient confidentiality in the past year were reported by 13% (6/46). Student use of profanity, frankly discriminatory language, depiction of intoxication, and sexually suggestive material were more commonly reported. Issues of conflict of interest were rare."

"Incidents were often reported to deans by trainees (57%; 26/46), nonfaculty staff (37%; 17/46), faculty (35%; 16/46), and rarely by patients or their family members (4%; 2/46). Disciplinary actions most frequently involved informal warnings (67%; 30/45). Other responses included no actions taken (16%; 7/45), formal disciplinary meetings (27%; 12/45), temporary suspension (2%; 1/45), and other (13%; 6/45)."

Table 2. Selected Survey Responses

Survey Questions	No. per Category/Total No. of Respondents (%)	
	Yes	No or Not Sure
Are you aware of any incidents at your school in which medical students have posted unprofessional content online?	47/78 (60)	31/78 (40)
Did any of these incidents in the past year involve violations of patient confidentiality?[a]	6/46 (13)	40/46 (87)
Did any of these incidents in the past year involve conflicts of interest?[a]	2/46 (4)	44/46 (96)
Did any of these incidents involve content that fits into the following categories[a]		
Profanity	22/42 (52)	20/42 (48)
Discriminatory language	19/40 (48)	21/40 (53)
Depicted intoxication	17/42 (40)	25/42 (60)
Sexually suggestive	16/42 (38)	26/42 (62)
Do your school's current professionalism policies cover student-posted online content?	28/73 (38)	45/73 (62)
Does your school's policy specifically address issues of Internet use such as blogs and social networking sites?[b]	5/28 (18)	23/28 (82)
Given your existing policies, do you feel you are able to effectively deal with unprofessional student-posted online content?	58/72 (81)	14/72 (19)
Is there a committee or task force at your school that is responsible for addressing student-posted online content?	14/73 (19)	59/73 (81)
Are you aware of any incidents at other schools in which medical students posted unprofessional content online?	20/75 (27)	55/75 (73)

[a] Answered if the response was yes to "Are you aware of any incidents at your school in which medical students have posted unprofessional content online?"
[b] Answered if the response was yes to "Do your school's current professionalism policies cover student-posted online content?"

"[…]38%(28/73) reported that their schools' policies broadly cover student-posted online content (Table 2). However, most of these (82%; 23/28) reported that the policies do not explicitly mention Internet use. Of the 46 respondents who

reported that their schools do not have policies to cover student-posted online content, 11%(5) were developing or revising existing policy to address this issue at survey time, 50% (23) were planning to make changes, 20% (9) did not feel any changes were necessary, and 20% (9) were not sure."

"Respondents reporting incidents vs those who did not were significantly more likely to report having a policy that covers student-posted online content (51% vs 18%; P=.006), having a policy that allows them to deal effectively with this issue (91% vs 63%; P=.003), and having the highest level of concern (20% vs 0%; P=.02 for difference in distribution of level of concern)."

"In 2001-2002, total medical student attrition was 673 out of a total enrollment of 66 673 (1.0%), including withdrawals and dismissals. Most cases were for academic, transfer, or personal reasons (618/673, [92%]).[15] Given prior work that connects unprofessional behavior in medical school with future state board disciplinary action,[16] involvement in unprofessional online posting might have similar prognostic significance […]"

"Certain examples, such as negative comments about a student's institution or profession, might not be considered unprofessional. The line separating protected First Amendment rights and inappropriate postings may be unclear."

"Notably, examples of students' public behaviors that fall into many of these categories have been documented long before the advent of the Internet.[17,18] Some, such as socially inappropriate medical student shows (in which medical students write and perform satirical comedy skits), may serve important coping and stress-release functions during difficult training[18]; however, when disseminated on media-sharing sites such as YouTube or Google Video, they carry the potential for significant public impact and viral spread of content."

"Medical students may not be aware of how online posting can reflect negatively on medical professionalism or jeopardize their careers.[20] Educating students about these concerns may change Internet behavior."

"The formal professionalism curriculum[24,25] should include a digital media component, which could include instruction on managing the "digital footprint," such as electing privacy settings on social networking sites and performing periodic Web searches of oneself."