

Perspective: Medical Education in Medical Ethics and Humanities as the Foundation for Developing Medical Professionalism

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Abstract

Medical education accreditation organizations require medical ethics and humanities education to develop professionalism in medical learners, yet there has never been a comprehensive critical appraisal of medical education in ethics and humanities. The Project to Rebalance and Integrate Medical Education (PRIME) I Workshop, convened in May 2010, undertook the first critical appraisal of the definitions, goals, and objectives of medical ethics and humanities teaching. The authors describe assembling a national expert panel of educators representing the disciplines of ethics, history, literature,

and the visual arts. This panel was tasked with describing the major pedagogical goals of art, ethics, history, and literature in medical education, how these disciplines should be integrated with one another in medical education, and how they could be best integrated into undergraduate and graduate medical education. The authors present the recommendations resulting from the PRIME I discussion, centered on three main themes. The major goal of medical education in ethics and humanities is to promote humanistic skills and professional conduct in physicians. Patient-centered skills enable learners to

become medical professionals, whereas critical thinking skills assist learners to critically appraise the concept and implementation of medical professionalism. Implementation of a comprehensive medical ethics and humanities curriculum in medical school and residency requires clear direction and academic support and should be based on clear goals and objectives that can be reliably assessed. The PRIME expert panel concurred that medical ethics and humanities education is essential for professional development in medicine.

Medical ethics and humanities teaching have become essential to teaching professionalism in medicine because the concept of professionalism is intrinsically scientific, clinical, ethical, and social. The Association of American Medical Colleges (AAMC) recognized the crucial role of such teaching as early as 1998 in a Medical School Objectives

Project (MSOP) report, *Learning Objectives for Medical Student Education: Guidelines for Medical Schools*, which included a series of “must” statements about medical student education regarding character and ethical behavior (Box 1).¹ Subsequent statements on ethics and professionalism and their role in the humanistic behavior of physicians from the Accreditation Council for Graduate Medical Education (ACGME), the Liaison Committee on Medical Education (LCME), the Joint Commission, and the United States Medical Licensing Examination (USMLE) and National Board of Medical Examiners (NBME) reinforce standards in these domains (Appendix 1).^{2–6}

Integrate Medical Education (PRIME) aims to enhance education in medical ethics and humanities by establishing benchmark standards for medical schools and residency training programs.

As a first step toward achieving the PRIME objective, we convened an expert panel of investigators to examine the role of medical ethics and humanities teaching in medical professionalism education. In this article we describe the selection of the panel members and the presentations and discussions that ensued. On behalf of the PRIME investigators, we present the recommendations that resulted from the first stage of this timely critical appraisal.

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More than 40 years after programs at such medical schools as Pennsylvania State University in Hershey and the University of Texas Medical Branch at Galveston began including medical ethics and humanities teaching in the undergraduate medical curriculum, it is time to critically appraise ethics and humanities medical educational methods and thereby make their role more explicit, robust, and accountable in the professional formation of medical students. The Project to Rebalance and

Professionalism, Post-Flexner

Abraham Flexner’s⁷ 1910 report to the Carnegie Foundation, with its central emphasis on the development of the physician–scientist, serves as a primary touchstone for PRIME. In addition to advocating improved teaching of basic and clinical sciences, Flexner argued for humanities education and the acquisition of humanistic skills.^{8–10} Over the past four decades, ethics and humanities educational programs have been

introduced into the U.S. medical curriculum. In the past decade, these programs have been further informed by the ACGME's enormously influential "general competencies" language adopted in the Common Program Requirements.² Professionalism grounds and justifies five of the ACGME's six core competencies (Patient Care, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-Based Practice).¹¹

The LCME requires education in "medical ethics, human values, and communication skills" with a learning environment promoting "adherence to ethical principles ... observed, assessed, and reinforced through formal instructional efforts" (Appendix 1).³ The Joint Commission stresses how the general competencies "including interpersonal and communication skills and professionalism" must be part of the clinician's hospital credentialing.⁴ The NBME and USMLE examine "Doctor–Patient Communication, Ethics, and Professionalism."^{5,6} The American Board of Internal Medicine underscored the importance of professionalism in its "Medical Professionalism in the New Millennium: A Physician Charter," which has been promulgated internationally.¹²

In the seminal DeCamp Foundation report published 25 years ago,¹³ basic medical ethics skills were identified, but

there has been no subsequent effort to undertake a comprehensive critical appraisal of medical ethics and humanities teaching in medical education. Most medical schools require medical ethics to be included in the curriculum,¹⁴ and many schools offer electives in the medical humanities, with some having required humanities curricula. National survey data indicate that medical ethics education in residency training programs is highly variable and often lacking.^{15,16} The first PRIME workshop (PRIME I) focused on how medical ethics and humanities achieve the goals and objectives of medical education, especially regarding professionalism.

Assembling the PRIME Panel

The authors (D.J.D., L.B.M., and S.W.) are the PRIME project leaders, and D.J.D. is the principal investigator on this two-year project to investigate how to effectively integrate medical ethics and humanities education into medical school and residency curricula. The foundations of PRIME lie in an earlier collaboration among the project leaders on an article about Abraham Flexner's essential role in promoting medical ethics and humanities in medical education, with an emphasis on art, ethics, history, and literature in medical education (List 1).⁹ Between 2010 and 2012, PRIME will have conducted two workshops

(PRIME I, described here, and PRIME II, held in May 2011), followed by a national symposium in May 2012.

For PRIME I, we used the method of the expert panel. The PRIME I investigators on this panel, who are listed at the end of this article, included educators in medical ethics and humanities from across the United States, representing the disciplines of ethics, history, literature, and the visual arts. Because of the synergistic relationship between medical ethics and law, we also included representation from health law. We selected representatives from the leadership of medical ethics and humanities programs as well as academic leadership. We tasked the PRIME I investigators with examining the "state of the art" of current medical ethics and humanities teaching (especially strengths and weaknesses), identifying challenges to integrating medical ethics and humanities teaching in the curriculum, and charting future directions. We selected the panel of PRIME I investigators using an iterative process based on four criteria:

1. Association with a core discipline of the medical humanities;
2. Experienced medical educators who had led development and implementation of a comprehensive curriculum in medical ethics and humanities at their home institution

List 1

The Art and Culture of Medicine: Examples of Medical Humanities Elements

Argument-Based Reasoning in Medical Ethics

Students learn to assess how ethical analysis and argument, the tools of argument-based ethics, apply to clinical care, research, and leadership by conforming their reasoning to the criteria for argument-based ethics, including clarity, consistency, coherence, clinical applicability, and clinical adequacy. [N.B., PRIME I Investigators added the following to this item description: Medical ethics has been, and will continue to be, strongly influenced and informed by law and by the results of descriptive ethics research using social science methodology, especially of anthropology and sociology.]

Narrative-Based Reasoning in Literature

Narrative reflection of patients and providers in the health care setting promotes students' insights into perspectives on illness and medical care other than their own, leading them to challenge the adequacy of their own views. Narrative reflection can also promote introspection and empathy, while providing enhanced perspective to the suffering of the healer and healed.

Creative Reasoning in the Fine Arts

The study of art history can train students in "slow looking," turning one's full visual attention to a work of art. The skills of slow looking are used when the physician turns his or her full visual attention to the patient's body during a physical examination, to the interpretation of images, and to anatomy exposed in a surgical field. The study of art history also emphasizes the social context in which images are created and interpreted, providing an opportunity to think critically about the roles of medical imaging in the clinical setting and in the broader visual culture.

Historical Reasoning in Learning

The study of the histories of medicine and science provides students with a critical perspective on contemporary medicine by requiring them to gain an understanding of how physicians thought and acted in the past. As a result, contemporary ways of thinking become open to critical appraisal. Students can thereby challenge the naïve view that with change comes progress in all cases.

Source: Doukas DJ, McCullough LB, Wear S. Reforming medical education in ethics and humanities by finding common ground with Abraham Flexner. List 1. *Acad Med.* 2010;85:318–323. Reprinted with permission.

(based on both Medline citations and on their institutional Web page);

3. A publication record in medical education; and,
4. An institutional program (department, center, institute, or division) with a publication record in education.

We applied these criteria to choose educators who have made substantive contributions to the field and are very well positioned to influence ethics and humanities education reform in the future. Panelists were invited to participate and were not allowed to self-nominate or nominate others. We assembled a total of 15 PRIME experts, including the 3 project leaders and the invited 12 expert panelists. The resulting expert panel represented major medical ethics and humanities teaching programs and disciplines in geographically diverse programs in the United States.

The PRIME I Workshop, 2010

The PRIME I Workshop was convened May 7–8, 2010 in Louisville, Kentucky, sponsored by the Department of Family and Geriatric Medicine of the School of Medicine of the University of Louisville. The project leaders' previous publication⁹ served as the point of departure for the work of the PRIME I Workshop. In this article, the project leaders advanced a Flexner-based argument that medical ethics and humanities teaching should build on medical students' and residents' cultural and philosophic background to inform their role as professional physician–scientists. PRIME I investigators also used the definitions of medical ethics, narrative-based reasoning in literature, visual experience and reflection in the fine arts, and historical reasoning from this article (List 1). Additionally, we distributed several publications on medical ethics and humanities education to the investigators before PRIME I to stimulate conversation (list provided on request).

PRIME seeks to effect sustainable change in medical ethics and humanities education as they contribute to professionalism in medical education. To this end, PRIME I had three specific goals: (1) describe the major pedagogical goals of art, ethics, history, and literature as disciplines contributing to professional formation in medical education, (2)

describe how the major pedagogical goals of art, ethics, history, and literature should be integrated with one another in medical education, and (3) describe how humanities education could be best integrated into preclinical and clinical medical education as well as into residency education.

The initial PRIME I session began with an overview by D.J.D. of changes in ethics and humanities education in the last century leading up to the recent emergence of the general competencies movement. The session concluded with a discussion of goals for both content and integration of art, ethics, history, and literature in the medical curriculum, and a discussion about integrating these topics with basic science, clinical medicine, and residency education. This opening session was followed by three working sessions, each of which included a presentation by one of the investigators from his or her disciplinary perspective with commentary from a colleague from another discipline to focus subsequent discussion. The first working session focused on the state of the art of medical education in art, ethics, history, and literature; the second on pedagogic methods and faculty development strategies in ethics and humanities education in medicine; and the third on curricular leadership from the perspective of the dean's office and the incoming president of the American Society for Bioethics and Humanities. A workshop summation then recapped the salient points raised by each session.

PRIME I Workshop proceedings were audio recorded (with participant permission) and subsequently transcribed. The project leaders analyzed the resulting transcript using inductive qualitative analysis (starting with the natural language expressions of participation and then organizing them into conceptually coherent and meaningful groups).¹⁷ Our goal was to identify the conceptualization of art, ethics, history, and literature and how they are taught within medical education, how new teaching modalities could enhance this education, and how ethics and humanities education could be integrated into medical education nationally. We gave specific consideration to school administration and national organizational support. For this analysis, project leaders read the

transcripts multiple times and independently identified major themes and subthemes. The project leaders then discussed and negotiated these themes and subthemes to develop a master list of themes and subthemes that incorporated each investigator's input. Differences in interpretation were minimal and readily negotiated. The draft list of themes was then circulated and edited by all the PRIME investigators for validation.

Themes: Skills and Conduct, Support, and Clarity

In this section, we describe the three main themes that emerged in the analysis of the PRIME I discussion: (1) Medical education in ethics and humanities cultivates humanistic skills and professional conduct in physicians, (2) implementation of a comprehensive medical ethics and humanities curriculum in medical school and residency requires clear direction and academic support, and (3) implementation of medical ethics and humanities teaching should be based on an articulation of clear goals and end points that can be realistically assessed.

Humanistic skills and professional conduct

The first theme concerns the relationships between professionalism in medicine and the teaching of medical ethics and humanities as essential components in the development of medical students and residents as professional physicians. The first relationship is instrumental: *Medical ethics and humanities teaching provides students and residents with a fund of knowledge and skills of reasoning, discernment, and judgment essential to sustainable professionalism in medicine.* To this end, medical ethics and humanities build skill sets in visual observation, textual reading and interpretation, oral reasoning, and writing.

Study of the visual arts through art history and through production of art works (i.e., studio art) cultivates slow looking: the disciplined observation, interpretation, and reflection on visual details and on the overall picture essential to conducting, and interpreting the results of, physical examination. Art is multidisciplinary in execution and is mostly elective in medical schools.

The study and creation of creative literature (short stories, novels, poetry, drama) encourage humanism and critical thinking and serve as a vehicle to improve care, commitment, and self-care. Literature teaches that in any given situation there are multiple perspectives, making suspect the privileging of any one perspective (e.g., the physician's versus that of the patient or family), thereby helping to encourage humanism in physicians by eliciting and seeking to understand both the physician's and the patient's stories. Given that most diagnoses can be made based on a thorough history alone, the skills of eliciting and interpreting patients' stories are crucial for the preparation of medical professionals and the provision of proper health care. The use of literature in medicine courses is also largely elective.

Study of medical ethics (required at almost all medical schools, but not in many residency programs) develops skills of moral discernment, reasoning, and normative judgment in the care of patients. Students and residents come to learn that the physician-patient relationship, in its myriad biopsychosocial dimensions, is an intrinsically moral enterprise. This subtheme was rooted to the DeCamp report a quarter of a century ago that formulated a list of essential skills in ethics in the physician-patient relationship.¹³ Investigators noted that physicians also have responsibilities beyond the physician-patient dyad to the rest of society, especially when functioning as agents of social change. It is in this context that the synergy between medical ethics and health law becomes relevant.

Study of the history of medicine helps medical students and residents to stand in the past so that what we now take for granted, which is usually invisible, becomes visible and therefore open for critical appraisal. History also teaches that medicine is a profoundly social enterprise requiring that the social dimensions of medicine be identified and critically appraised. Again, as in art, history in medicine is largely elective.

The need for critical appraisal brought out a second relationship between professionalism in medicine and medical ethics and humanities teaching: *Medical*

ethics and humanities teaching have an essential role to play in equipping medical students and residents with the tools to critically appraise the goals that the profession of medicine ought to pursue, ways the physician-patient relationship should be improved, and how the medical profession should understand and manage its complex relationship with society, especially through health policy and the institutions of self-government. Analytical decision making and critical self-reflection are end products of medical ethics and humanities education. These, in turn, promote critical appraisal of medicine. The result is physicians who should not be satisfied with the current fund of knowledge and skills. Medical ethics and humanities thereby contribute to the cultivation by students and residents of a lifelong commitment to medicine as a deliberate practice through transformative learning.^{18,19} The medical humanities foster habits of mind essential for self-assessment and virtuous comportment while promoting critical thinking regarding observation, introspection, reflection, and analysis.

Medical ethics and humanities challenge a narrowly construed, reductionist vision of the goals of medical education by teaching students to think expansively, thereby engaging in a critical appraisal of concepts such as medical professionalism. Critical appraisal skills help students ask how U.S. health care might be flawed as well as how it could be improved. Such skills also allow medical learners to become comfortable with uncertainty as a manageable rather than paralyzing challenge. Medical ethics and humanities teaching may even be viewed as a "subversive activity" because the learners ask: "What do we need to change, and from what to what? Why?" Such questions are not an arrogant threat to the status quo; rather, they are essential to lifelong learning and the ongoing evolution of knowledge, skills, and critical thinking that medical practice requires.

Clear direction and academic support

The PRIME I investigators emphasized the importance of thinking outside the confining box of time and hours in the curriculum. Medical ethics and humanities teaching, in the spirit of Flexner, should focus not only on what is

lacking in learners but also on what each student brings to his or her medical school experience. At the same time, medical educators should assume that most students do not understand what professionalism in medicine means and requires of them. This includes especially one of the core values of professionalism: accountability achieved by evidence-based (basic and clinical sciences) and argument-based (medical ethics and humanities) reasoning. The goals of medical ethics and humanities teaching should be clearly articulated and explicitly linked to consensus goals of professionalism and, via external guidelines from LCME, ACGME, MSOP, USLME, etc., to those aspects of professionalism that lend themselves to reliable evidence-based quantitative and qualitative assessment (Box 1, Appendix 1).^{5,7} Investigators judged forging this link to be the key to achieving sustainable programs in medical ethics and humanities.

Medical schools will have varying faculty strengths and economics. PRIME I investigators called for the creation of a central, accessible depository of pedagogical resources to assist in implementation to support medical schools with less robust faculty resources. Funding ethics and humanities teaching for faculty development and support, as well as providing curricular time and space needs for seminar teaching, should be carefully considered, for academic leadership will rightly require clarity, specificity, and evaluation in these requests.

Clarity and assessment of goals and objectives

The goals and objectives of medical ethics and humanities teaching should be articulated clearly to conform to the discourse of AAMC, LCME, etc., they must be flexible regarding time and hours, and they must focus on goals and objectives expressed as assessable outcomes with implementable pedagogical tactics when such metrics are available and valid.^{5,7} Effective teaching of medical ethics and humanities requires flexibility—that is, multiple styles and resources with collaborative, interdisciplinary teaching methods that progress from normative education, to teaching and observing conduct, to inculcating values that promote humanistic behavior. Successful pedagogies address the challenges of lack

Box 1

Excerpts From the Association of American Medical Colleges Medical School Objectives Project Report I, Learning Objectives for Medical Student Education: Guidelines for Medical Schools, 1998*

Physicians must be altruistic. Physicians must be compassionate and empathetic in caring for patients, and must be trustworthy and truthful in all of their professional dealings. They must bring to the study and practice of medicine those character traits, attitudes, and values that underpin ethical and beneficent medical care. They must understand the history of medicine, the nature of medicine's social compact, the ethical precepts of the medical profession, and their obligations under law. At all times they must act with integrity, honesty, respect for patients' privacy, and respect for the dignity of patients as persons. In all of their interactions with patients they must seek to understand the meaning of the patients' stories in the context of the patients' beliefs, and family and cultural values. They must avoid being judgmental when the patients' beliefs and values conflict with their own. They must continue to care for dying patients even when disease-specific therapy is no longer available or desired. [page 4]

For its part the medical school must ensure that before graduation a student will have demonstrated, to the satisfaction of the faculty, the following:

- Knowledge of the theories and principles that govern ethical decision making, and of the major ethical dilemmas in medicine, particularly those that arise at the beginning and end of life and those that arise from the rapid expansion of knowledge of genetics
- Compassionate treatment of patients, and respect for their privacy and dignity
- Honesty and integrity in all interactions with patients' families, colleagues, and others with whom physicians must interact in their professional lives
- An understanding of, and respect for, the roles of other health care professionals, and of the need to collaborate with others in caring for individual patients and in promoting the health of defined populations
- A commitment to advocate at all times the interests of one's patients over one's own interests
- An understanding of the threats to medical professionalism posed by the conflicts of interest inherent in various financial and organizational arrangements for the practice of medicine
- The capacity to recognize and accept limitations in one's knowledge and clinical skills, and a commitment to continuously improve one's knowledge and ability [pages 4–5]

* Source: Association of American Medical Colleges Medical School Objectives Project. Learning Objectives for Medical Student Education: Guidelines for Medical Schools. Washington, DC: Association of American Medical Colleges; 1998. Copyright © 2008 Association of American Medical Colleges. All rights reserved. Reproduced with permission.

of continuity in medical school, the hidden curriculum, and differences in adult learning styles.

PRIME I investigators called for medical humanities to become a required part of the medical curriculum, just as medical ethics is currently and as is called for by the AAMC. This curriculum should use interdisciplinary teaching and should assess appropriate outcomes that must be developed by ethics and humanities educators, with clear relevance for learners and educators in both preclinical and clinical settings, and having translational applicability to professional, humanistic patient care.

Rethinking "Skills"

PRIME I investigators emphasized the need for medical educators to appreciate the difference between ethics and humanities taught at the undergraduate, college, and university level and the medical ethics and humanities taught in medical schools. The justification for ethics and humanities teaching differs significantly based on the setting. General humanities education promotes the preparation of informed, critical thinkers for citizenship and leadership of the institutions of commerce, education, philanthropy, faith communities, and

government. Medical humanities education aims at making the learner a better physician who has a lifelong commitment to medical professionalism.

Medical ethics and humanities promote this professional commitment by teaching two essential skill sets. The first set, patient-centered skills, enables students to become medical professionals and residents to excel as medical professionals. The discipline of ethics teaches learners to manage ethical dimensions of patient care responsibly. The discipline of literature teaches attention to narratives as learners reconstruct patient stories into medical histories that are necessary for accurate diagnosis and effective clinical management. The discipline of art teaches intense, detailed, and comprehensive observation. The discipline of history provides historical context that can help prevent a naïve view of progress that blinds learners to the limits of medicine. In their own ways, each of these disciplines promotes empathetic relationships with patients, which enhance compassion in medicine.

The second skill set, critical thinking skills, enables students and residents to critically appraise the concept and

implementation of medical professionalism so that they can adapt it responsibly to the ambiguity and uncertainties of future medical care. Critical thinking skills contribute to performing the patient-centered skills required of the physician and can inform our understanding of how learners feel, as well as how they think, contributing to the education of the emotional intelligence of future physicians. Critical thinking skills address how the medical learner "processes" the healing experience in caring for patients, with an emphasis on how to observe, reflect, and analyze, thereby serving as the foundation to learning patient-centered skills.

PRIME I investigators concurred as an expert consensus panel that medical ethics and humanities teaching is essential for the cultivation of humanistic and critical thinking attitudes and skills that promote medical professionalism. The explicit linkage of medical ethics and humanities teaching to medical professionalism marks an important shift from the DeCamp Report, which emphasized ethics solely as a means toward developing essential clinical skills.⁸ Forging this link also positions medical ethics and humanities to contribute to the achievement of the

educational mandates of professionalism by accreditation and testing organizations (Box 1, Appendix 1).

Next Steps for PRIME

The next steps for PRIME will address how medical education can better incorporate medical ethics and humanities through curriculum standardization and assessment. The 2011 PRIME II Workshop will again engage the expert panel approach and will also include leaders of AAMC, ACGME, and LCME. The participants will address the following four questions:

1. Which medical school and residency learning objectives—especially, but not limited to, professionalism—do study in medical ethics and humanities support?
2. How should study of medical ethics and humanities be improved so that it more effectively and demonstrably (i.e., using sound assessment means) contributes to the achievement of current medical school and residency learning objectives?
3. How should medical school and residency learning objectives—especially, but not limited to, professionalism—be critically appraised?
4. How should study of medical ethics and humanities be improved so that it more effectively and demonstrably contributes to the achievement of medical school and residency learning objectives that are defined/refined as a result of this critical appraisal?

These questions will be the framework for a comprehensive curriculum reform that will be presented at the National Conference on Medical Ethics and Humanities in Medical Education at the University of Louisville School of Medicine on May 10–11, 2012.²⁰ This conference will be inclusive to all educators and administrators in medical education. The PRIME 2012 National Conference will be an open dialogue on how to formulate a national framework on integrating ethics and humanities into the required curricula in all U.S. medical schools and residency training programs. An outcomes-based agenda for future empirical research in medical education design will enable the programmatic educational research to demonstrate an evidence-based rationale for the inclusion of ethics and humanities in medical education.

We acknowledge that expert panels, such as the PRIME I investigators, can suffer from flawed selection criteria, resulting in the promotion of colleagues rather than an agenda, but we managed this limitation in PRIME I by adhering to rigorous selection criteria, based on multiple perspectives of scholarship and curriculum success. Although this method could overlook excellent work by a single person or small group in medical education, we plan to seek out these voices for the 2012 national conference with widely publicized efforts to encourage participation in the symposium.

Promoting Professionalism for the Future

Statements on education from AAMC, LCME, and ACGME agree that teaching medical ethics and humanities is essential to the goals of professional formation and development in medical education. The PRIME I expert panel concurred that medical ethics and humanities instruction in medical schools teaches essential elements of the ACGME general competencies (and other accreditation standards) regarding conduct and critical appraisal skills essential to developing the formation of medical students and residents into professional physicians. PRIME will continue to lead reform in medical ethics and humanities education that explicitly and measurably promotes the mastery of patient-centered skills and critical thinking skills in the coming generations of medical students and residents.

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Appendix 1

Excerpts From Accreditation Standards Related to Professionalism

Accreditation Council for Graduate Medical Education

Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Residents are expected to:

- ... demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- ... demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- ... demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

Source: Accreditation Council for Graduate Medical Education. General Competency and Assessment: Common Program Requirements. Page 9. http://www.acgme.org/acWebsite/dutyHours/dh_dutyhoursCommonPR07012007.pdf. Accessed November 17, 2011.

Liaison Committee on Medical Education

ED-23. A medical education program must include instruction in medical ethics and human values and require its medical students to exhibit scrupulous ethical principles in caring for patients and in relating to patients' families and to others involved in patient care.

The medical education program should ensure that medical students receive instruction in appropriate medical ethics, human values, and communication skills before engaging in patient care activities. As students take on increasingly more active roles in patient care during their progression through the curriculum, adherence to ethical principles should be observed, assessed, and reinforced through formal instructional efforts....

The phrase "scrupulous ethical principles" implies characteristics that include honesty, integrity, maintenance of confidentiality, and respect for patients, patients' families, other students, and other health professionals.

MS-31-A. A medical education program must ensure that its learning environment promotes the development of explicit and appropriate professional attributes in its medical students (i.e., attitudes, behaviors, and identity).

The medical education program, including its faculty, staff, medical students, residents, and affiliated instructional sites, shares responsibility for creating an appropriate learning environment. The learning environment includes both formal learning activities and the attitudes, values, and informal "lessons" conveyed by individuals who interact with the medical student....

It is expected that a medical education program will define the professional attributes it wishes its medical students to develop in the context of the program's mission and the community in which it operates. Such attributes should also be promulgated to the faculty and staff of the medical education program. As part of their formal training, medical students should learn the importance of demonstrating the attributes of a professional and understand the balance of privileges and obligations that the public and the profession expect of a physician....

The medical education program and its faculty, staff, medical students, and residents should also regularly evaluate the learning environment to identify positive and negative influences on the maintenance of professional standards and conduct and develop appropriate strategies to enhance the positive and mitigate the negative influences. The program should have suitable mechanisms available to identify and promptly correct recurring violations of professional standards.

Source: Liaison Committee on Medical Education. Accreditation Standards. Revised May 2011. <http://www.lcme.org/functions2011may.pdf>. Accessed November 11, 2011. Copyright © May 2011 Liaison Committee on Medical Education. All rights reserved. Reproduced with permission.

The Joint Commission

Standards in the "Medical Staff" chapter require that the six general competencies adopted by the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education be addressed in the credentialing process, including interpersonal and communication skills and professionalism, all of which are incompatible with intimidating and disruptive behavior.

Source: The Joint Commission. Leadership in Healthcare Organizations: A Guide to Joint Commission Leadership Standards. Winter 2009. http://www.jointcommission.org/assets/1/18/WP_Leadership_Standards.pdf. Accessed November 11, 2011.

National Board of Medical Examiners

The APB [Assessment of Professional Behaviors] Program supports continuous learning among residents, fellows, and faculty around communication and interpersonal skills, professionalism, and practice-based learning and improvement.

Through multisource feedback, physicians at all levels of training and practice can gain broad perspective on behaviors observed by their colleagues. By bringing a standardized approach to assessment of professional behaviors, the program also helps departments and institutions strengthen training and mentoring.

Source: National Board of Medical Examiners. Assessment of Professional Behaviors Program. Revised August 22, 2011. <http://www.nbme.org/schools/apb/index.html>. Accessed November 11, 2011.

United States Medical Licensing Examination (USMLE)

- ... USMLE governance will consider changes to the examination sequence in the context of competencies that have become increasingly prevalent in recent years as a means of organizing medical education and assessment. One of the most commonly used competency frameworks was developed collaboratively by the ACGME [Accreditation Council for Graduate Medical Education] and the ABMS [American Board of Medical Specialties]. This framework identifies six competencies: medical knowledge, patient care, communication and interpersonal skills, professionalism, practice-based learning and improvement, and systems-based practice.

Source: United States Medical Licensing Examination. Comprehensive Review of USMLE. Frequently Asked Questions: What are the "competencies? Are they all going to be assessed in USMLE? How? <http://www.usmle.org/frequently-asked-questions/#cru>. Accessed November 11, 2011.