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From Teaching Professionalism to Supporting Professional Identity Formation: Lessons from Medicine

Sylvia R. Cruess

Richard L. Cruess

From Teaching Professionalism to Supporting Professional Identity Formation: Lessons from Medicine*

by Sylvia R. Cruess**

and Richard L. Cruess***

I. INTRODUCTION

Profession, professional, and professionalism are generic terms that apply to a limited number of knowledge-based occupations charged with providing essential services to society. While the terms have existed for over 2000 years, until the middle of the nineteenth century the professions served only the upper socioeconomic strata and thus had a limited impact on society.[1] The reasons were not complex. Wealth was limited

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**Professor of Medicine and a Core Faculty Member of the Centre for Medical Education of McGill University. She is an endocrinologist, and served as Director of the Metabolic Day Centre (1968-1978) and as Medical Director of the Royal Victoria Hospital (1978-1995) in Montreal. Vassar College (B.A. 1951); Columbia University (M.D. 1955). She is an Officer of the Order of Canada, and in 2011 McGill University established the Richard and Sylvia Cruess Chair in Medical Education.

***Professor of Surgery and a Core Faculty Member of the Centre for Medical Education of McGill University. He is an orthopedic surgeon, and he served as Chair of Orthopedics (1976-1981), directing a basic science laboratory and publishing extensively in the field. He was Dean of the Faculty of Medicine at McGill University from 1981 to 1995. He was President of the Canadian Orthopedic Association (1977-1978), the American Orthopedic Research Society (1975-1976), and the Association of Canadian Medical Colleges (1992-1994). He is a Companion of The Order of Canada and of L'Ordre National du Québec. Princeton University (B.A. 1951); Columbia University (M.D. 1955). McGill University has established the Richard and Sylvia Cruess Chair in Medical Education.

1. *See* ELLIOT KRAUSE, DEATH OF THE GUILDS: PROFESSIONS, STATES AND THE ADVANCE OF CAPITALISM, 1930 TO THE PRESENT (1996).

and only a few could afford the services of the professional until the industrial revolution provided sufficient resources to support their use. The growth in both size and influence of the medical and legal professions occurred at this time. In the case of medicine, the period coincided with the development of modern science, making the services of the healer worth purchasing. The increasing complexity of industrial societies led to increasing demands for legal services. The result in both professions was an expansion of educational facilities in an attempt to improve their quality and to provide sufficient professionals.[2]

While there are many attributes shared by the medical and legal professions, including definitions, their relationship to society, and certain regulatory processes, there has always been a fundamental difference in their educational systems. Sullivan and his colleagues said it well in *Educating Lawyers*:[3] "The distinguishing feature of medical training, however, is that most of it is carried out in settings of actual patient care. The consequence is to provide medicine a real advantage, compared to engineering or law, for integrating its forms of apprenticeship."[4]

A fundamental principle of medical education is the allocation of increasing levels of both involvement in and responsibility to learners for patient care throughout the educational continuum.[5] In virtually every medical school, contact with real patients begins very early in the first year of medical education, and the proportion of time spent with patients increases until learners are fully occupied in actual care as they graduate from medical school. This process continues as they proceed into the postgraduate training that is required prior to licensure. In contrast, in legal education actually serving clients is largely deferred until after graduation.[6] For this reason, transposing experience gained in medical education directly to the law is complicated. Nevertheless, lessons can be learned in relation to overall curricular design and to specific educational strategies that have been developed.

II. THE ISSUE OF PROFESSIONALISM

This dichotomy is particularly important when one considers the necessity to pass on the historical values and attitudes traditionally associated with the professions. To accomplish this task, medicine has always

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2. *Id.*

3. *See* WILLIAM M. SULLIVAN ET AL., EDUCATING LAWYERS: PREPARATION FOR THE PROFESSION OF LAW (2007).

4. *Id.* at 81.

5. *See* KENNETH M. LUDMERER, LEARNING TO HEAL: THE DEVELOPMENT OF AMERICAN MEDICAL EDUCATION (1985).

6. *See* SULLIVAN ET AL., *supra* note 3.

leaned heavily on role models and mentors functioning in clinical situations, thus assuring continuity within the profession.[7] Until recently, this essential educational experience was rarely made explicit, with individual learners modelling their own behaviors after those whom they respected. Professionalism was not taught.[8] This changed in the latter half of the twentieth century as all forms of authority were greeted with skepticism, and medicine became a much more lucrative occupation, leading to an increase in conflicts of interest. Medicine came to believe that its professionalism was being threatened, with the threats arising from within and without the profession. Failure to control conflicts of interest and lax self-regulation were seen to be within medicine's own domain.[9] The reliance on the marketplace to control both the quality and costs of healthcare were believed to force physicians to become entrepreneurs in a competitive environment, thus threatening the traditional values of the profession. Medicine's response, which has often been termed defensive in nature, centered on its educational system.[10]

III. TEACHING PROFESSIONALISM

"Professionalism must be taught" became a rallying cry in medicine, and a consensus developed that what had been an implicit part of the curriculum must be made explicit.[11] In attempting to do so, it became apparent that the profession itself knew very little about professionalism, in part because the very rich literature on the subject existed largely in the social sciences and was not readily available to medical educators. When anything is to be taught and assessed, both teachers and learners must clearly understand the nature of the subject.[12] For this reason, in developing a curriculum to specifically teach professionalism, it became necessary to develop definitions and a list of the attributes characteristic

7. *See* Nuala P. Kenny et al., *Role Modeling in Physicians' Professional Formation: Reconsidering an Essential but Untapped Educational Strategy*, 78 ACAD. MED. 1203 (2003).

8. *See* Richard L. Cruess & Sylvia R. Cruess, *Teaching Medicine as a Profession in the Service of Healing*, 72 ACAD. MED. 941 (1997) [hereinafter Cruess, *Teaching Medicine*].

9. *Id.*

10. *Id.*

11. *See* Sylvia R. Cruess & Richard L. Cruess, *Professionalism Must be Taught*, 315 BMJ 1674 (1997).

12. *See* DAVID A. KOLB, EXPERIENTIAL LEARNING: EXPERIENCE AS THE SOURCE OF LEARNING AND DEVELOPMENT (1984).

of the "good professional." We have termed these essential elements the "cognitive base of professionalism."[13]

Several acceptable definitions appeared, including a widely accepted "International Charter on Medical Professionalism" developed by the international internal medicine community.[14] To serve as the foundation of a teaching program at McGill University, we chose to define profession as the foundational word of both professional and professionalism, as seen below:

> Profession: An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society.[15]

As stated in the definition, professionalism is the basis of a profession's social contract with society. Society uses the concept of the profession to assist in the organization of the delivery of essential services that are required.[16] In medicine, it is the services of the healer that must be organized.[17] We would suggest that in the law it is the adjudicator of disputes. This separation of roles can be justified if one takes an historical perspective. Healers have existed in society since before recorded history, and it seems probable that designated individuals were also entrusted with the task of adjudicating disputes. While there was some organization of both professions before the middle of the nineteenth century, only at that time, through the enactment of licensing laws, did the modern professions

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13. Richard L. Cruess & Sylvia R. Cruess, *Teaching Professionalism: General Principles*, 28 MED. TEACHER 205, 205 (2006) [hereinafter Cruess, *Teaching Professionalism*].

14. *See* T. Brennan et al., *Medical Professionalism in the New Millennium: A Physician's Charter*, 136 ANN. INT. MED. 243 (2002).

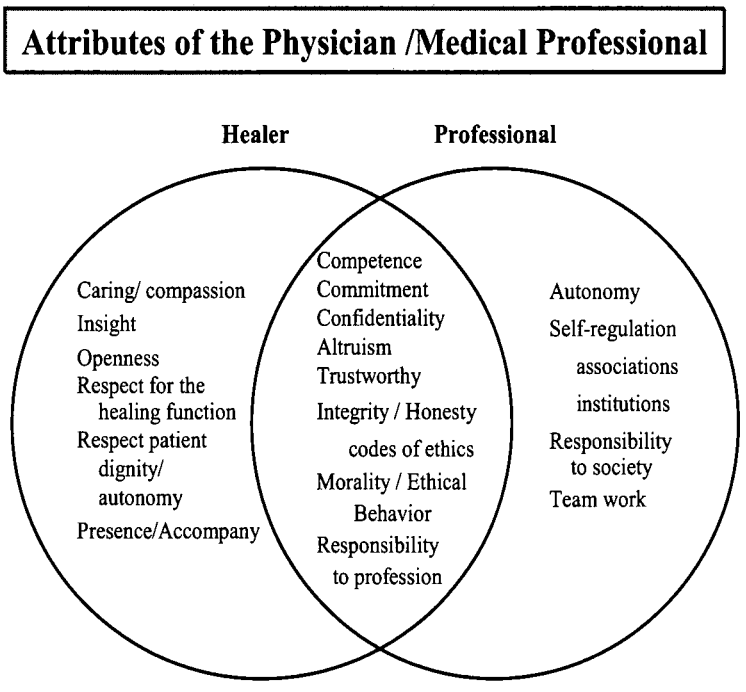
15. Sylvia R. Cruess et al., *Profession: A Working Definition for Medical Educators*, 16 TEACHING & LEARNING IN MED. 74, 75 (2004).

16. *See* Cruess, *Teaching Medicine*, *supra* note 8; WILLIAM M. SULLIVAN, WORK AND INTEGRITY: THE CRISIS AND PROMISE OF PROFESSIONALISM IN NORTH AMERICA (2d ed. 2005).

17. *See* Cruess, *Teaching Medicine*, *supra* note 8.

come into being.[18] This concept allows one to identify the attributes of both the healer (and of course the adjudicator of disputes) and of the professional. Figure 1 provides this information in medicine, with the attributes of each role having been derived from the extensive literature on the subject.[19]

Figure 1



The attributes traditionally associated with the healer are shown in the left-hand circle and those with the professional on the right. As can be seen, there are attributes unique to each role. Those shared by both are found in the large area of overlap of the circles. This list of attributes is drawn from the literature on healing and professionalism.

18. *See* KRAUSE, *supra* note 1; SULLIVAN, *supra* note 16.

19. *See* Richard L. Cruess & Sylvia R. Cruess, *Professionalism and Professional Identity Formation: The Cognitive Base*, *in* TEACHING MEDICAL PROFESSIONALISM (Richard L. Cruess et al. eds., 2009) [hereinafter Cruess, *Professionalism*].

A further fundamental part of the cognitive base is the nature of the social contract that essentially constitutes a "bargain" between professions and society.[20] Society grants to a profession considerable autonomy in practice, prestige, and financial rewards, and the privilege of self-regulation on the understanding that the profession will demonstrate honesty and integrity in its activities, be altruistic, devote itself to issues of importance to society, and assure competence through rigorous self-regulation.[21] There are thus expectations that medicine has of society and that society has of medicine. Societal expectations are outlined in the list of attributes found in Figure 1. Failure to meet societal expectations will inevitably lead to an alteration in the social contract.[22]

With a cognitive base as its foundational element, virtually every medical school proceeded to develop a longitudinal curriculum with the important elements being found throughout the educational continuum. Figure 2 offers a schematic representation of the approach taken.

The cognitive base must be introduced early in the educational process and should be reinforced by repetition with increasing levels of sophistication throughout the curriculum.[23] However, the subject must not remain theoretical. It is important that learners internalize the value systems of the medical profession, a process that is facilitated by reflection. Role models remain as extremely powerful influences and are encouraged to make issues explicit.[24] Opportunities to reflect on important issues relevant to professionalism must be provided at regular intervals throughout the curriculum, with the emphasis being on points of tension that will be experienced by most students.[25] Examples of these points of tension include how the great importance of work-life balance voiced by current students often conflicts with altruism as well as the constant problems posed by both conflicts of interest and self-regulation.[26]

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20. *See* SULLIVAN, *supra* note 16; Richard L. Cruess & Sylvia R. Cruess, *Expectations and Obligations: Professionalism and Medicine's Social Contract with Society*, 51 PERSPECTIVES IN BIOLOGY & MED. 579 (2008).

21. *Id.*

22. *Id.*

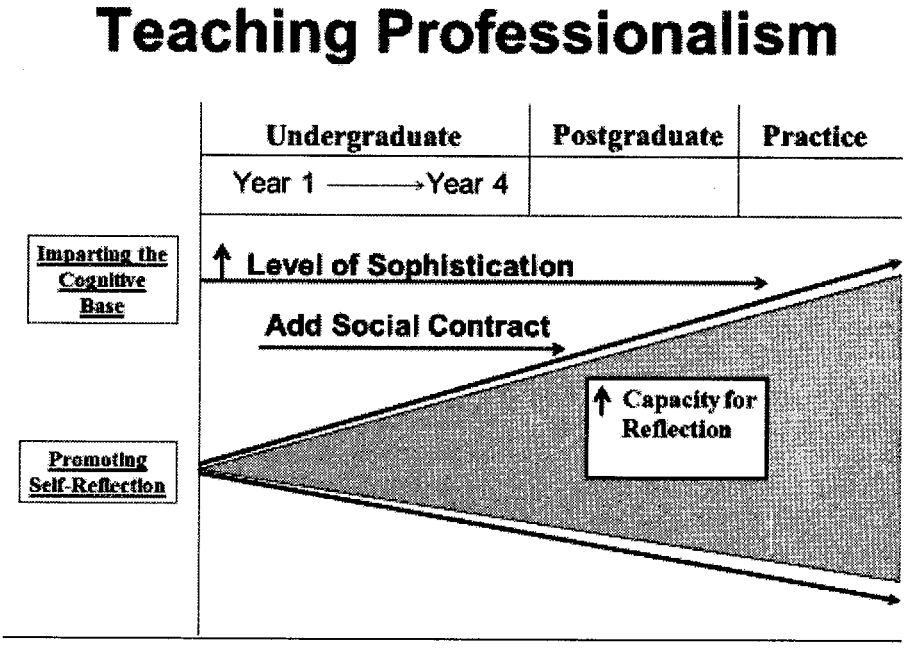
23. *See* Cruess, *Teaching Professionalism*, *supra* note 13; Cruess, *Professionalism*, *supra* note 19.

24. *See* Kenny, *supra* note 7.

25. *See* Ronald M. Epstein, *Reflection, Perception and the Acquisition of Wisdom*, 42 MED. EDUC. 1048 (2008); Karen Mann et al., *Reflection and Reflective Practice in Health Professions Education: A Systematic Review*, 14 ADVANCES IN HEALTH SCI. EDUC. 595 (2009).

26. *See* Andrew H. Brainard & Heather C. Brislen, *Viewpoint: Learning Professionalism: A View from the Trenches*, 82 ACAD. MED. 1010 (2007).

Figure 2



The cognitive base of professionalism, including definitions and lists of attributes, must be presented early in the course of medical education and repeated with increasing levels of sophistication throughout the educational continuum. As learners gain both maturity and experience, opportunities to reflect, appropriate to the learner's level, on these experiences must be provided.

Methods to assess the professionalism of learners were also developed. Because values and attitudes are subjective in nature, the emphasis devolved into the assessment of observable behaviors representative of professional values.[27] An assumption was made that if individuals behave like professionals, they would be professionals.

27. *See* Tim J. Wilkinson et al., *A Blueprint to Assess Professionalism: Results of a Systematic Review*, 84 ACAD. MED. 551 (2009); Brian D. Hodges et al., *Assessment of Professionalism: Recommendations from the Ottawa 2010 Conference*, 33 MED. TEACHER 354 (2011).

Finally, an extremely important action was taken by the medical educational establishment throughout the English-speaking world. The teaching and assessment of professionalism was made a requirement for accreditation at both the undergraduate and postgraduate levels, thus ensuring that all educational programs comply.[28]

IV. THE CHANGE IN EMPHASIS TO PROFESSIONAL IDENTITY

From the time that actively teaching professionalism was proposed, an existential question was always present: Can professionalism actually be taught?[29] Or, as Hafferty succinctly asked, does medical practice require a professional presence best based in what one is rather than what one does?[30]

Throughout this period, a small group of medical educators were examining the concept of identity formation in medicine, basing their approach on the very rich literature found largely in developmental psychology and the world of business.[31] Understanding gradually emerged that during the course of their educational experiences, medical students

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28. *See* Liaison Comm. on Med. Educ., Regulation MS 31A, FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL: STANDARDS FOR ACCREDITATION OF MEDICAL EDUCATION PROGRAMS LEADING TO THE M.D. DEGREE (2012); Jason R. Frank & Deborah Danoff, *The CanMEDS Initiative: Implementing an Outcomes-based Framework of Physician Competencies*, 29 MED. TEACHER 642 (2007); ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., ACGME COMMON PROGRAM REQUIREMENTS (2016), http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_07012016.pdf (last visited Mar. 1, 2017) (professionalism is one of the required core competencies of ACGME).

29. *See* Jack Coulehan & Peter C. Williams, *Vanquishing Virtue: The Impact of Medical Education*, 76 ACAD. MED. 598 (2001).

30. *See* Frederic William Hafferty, *Socialization, Professionalism, and Professional Identity Formation*, *in* TEACHING MEDICAL PROFESSIONALISM 55 (Richard L. Cruess et al. eds., 2009).

31. *See* Caragh Brosnan, *Pierre Bourdieu and the Theory of Medical Education: Thinking 'Relationally' About Medical Students and Medical Curricula*, *in* HANDBOOK OF THE SOCIOLOGY OF MEDICAL EDUCATION (Caragh Brosnan & Bryan S. Turner eds., 2009); Anna MacLeod, *Caring, Competence and Professional Identities in Medical Education*, 16 ADVANCES IN HEALTH SCI. EDUC. 375 (2011); Lynn V. Monrouxe, *Identity, Identification and Medical Education: Why Should We Care?*, 44 MED. EDUC. 40 (2010); Lynn V. Monrouxe et al., *Differences in Medical Students' Explicit Discourses of Professionalism: Acting, Representing, Becoming*, 45 MED. EDUC. 585 (2011); Bryan Burford, *Group Processes in Medical Education: Learning from Social Identity Theory*, 46 MED. EDUC. 143 (2012); John Goldie, *The Formation of Professional Identity in Medical Students: Considerations for Educators*, 34 MED. TEACHER 641 (2012); Esther Helmich et al., *Entering Medical Practice for the Very First Time: Emotional Talk, Meaning and Identity Development*, 46 MED. EDUC. 1074 (2012); Sandra Jarvis-Selinger et al., *Competency is not Enough: Integrating Identity Formation into the Medical Education Discourse*, 87 ACAD. MED. 1185 (2012).

and residents come to acquire the identity of a physician.[32] This development did not have a significant impact until the landmark study of medical education carried out by the Carnegie Foundation recommended that identity formation become a foundational element of the education of all professions, including medicine.[33] This required a reassessment of the movement to teach professionalism, and it became apparent to many that one of the ultimate objectives of medical education was to support individuals as they develop their professional identities.[34] Thus, the teaching of professionalism was a means to an end, not an end in itself.

This concept was not new. Merton, in the first comprehensive study of the sociology of medical education, had written in 1957 that it is the function of undergraduate and postgraduate medical education to "transmit the culture of medicine [and] . . . to shape the novice into an effective practitioner of medicine, to give him the best available knowledge and skills, and to provide him with a professional identity so that he comes to think, act, and feel like a physician."[35]

Thus, there has been a fundamental re-evaluation of medical education, with a large number of institutions reorienting their curricula with the specific objective of graduating practitioners who "think, act, and feel" like physicians.[36]

V. COMMUNITIES OF PRACTICE AND PROFESSIONAL IDENTITY FORMATION

Professional education can be better understood if it rests on a base of sound educational theory. Concomitant with interest in identity formation has been a growing belief that the social learning theory "community of practice," proposed by Lave and Wenger, can be of great assistance

32. *See* Monrouxe, *supra* note 31; Burford, *supra* note 31; Goldie, *supra* note 31; Helmich, *supra* note 31; Jarvis-Selinger, *supra* note 31.

33. *See* MOLLY COOKE ET AL., EDUCATING PHYSICIANS: A CALL FOR REFORM OF MEDICAL SCHOOL AND RESIDENCY (2010).

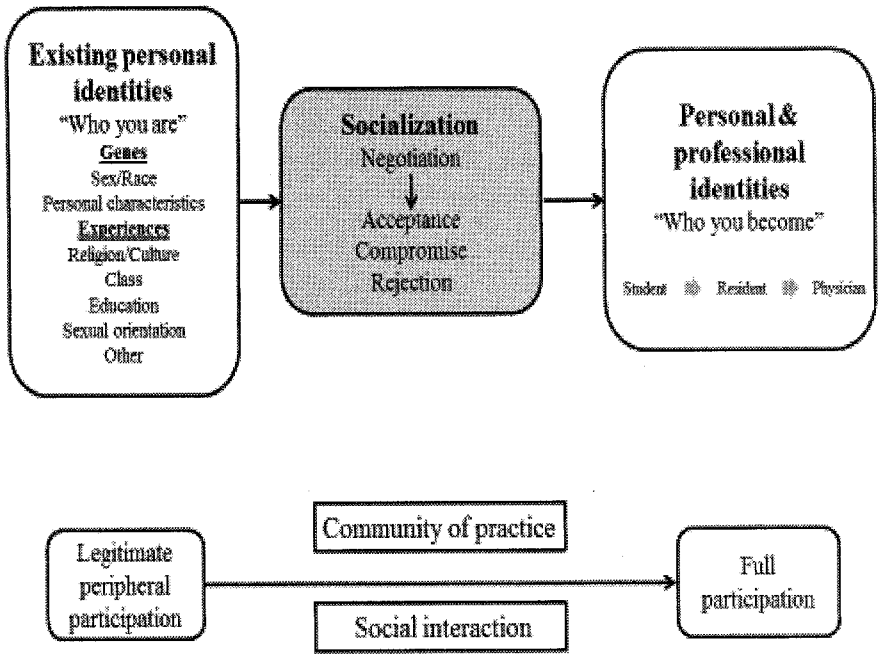
34. *See* Richard L. Cruess et al., *Reframing Medical Education to Support the Development of Professional Identity Formation*, 89 ACAD. MED. 1446 (2014) [hereinafter Cruess, *Reframing Education*].

35. *See* Robert K. Merton, *Some Preliminaries to a Sociology of Medical Education*, *in* THE STUDENT PHYSICIAN: INTRODUCTORY STUDIES IN THE SOCIOLOGY OF MEDICAL EDUCATION 7 (Robert K. Merton et al. eds., 1957).

36. *See* Cruess, *Professionalism*, *supra* note 19; Cruess, *Reframing Education*, *supra* note 34.

in both understanding medical education and guiding educational strategies.[37] Figure 3 illustrates the concept, along with its relationship to identity formation.[38]

Figure 3



Individuals voluntarily join medicine's community of practice at a particularly formative phase, but with an existing identity. The process of socialization leads to the development of an identity appropriate for a student, a resident, and finally a practicing physician. Reprinted with permission by Academic Medicine, 2016.

37. *See* JEAN LAVE & ETIENNE WENGER, SITUATED LEARNING: LEGITIMATE PERIPHERAL PARTICIPATION (1991).

38. *See* Richard L. Cruess et al., *A Schematic Representation of the Professional Identity Formation and Socialization of Medical Students and Residents: A Guide for Medical Educators*, 90 ACAD. MED. 718 (2015) [hereinafter Cruess, *Schematic Representation*].

We would suggest the following definition of community of practice, based on that of Lave and Wenger:[39]

> A community of practice is composed of individuals who voluntarily engage in a process of collective learning in a shared domain of human endeavor. This shared domain is the basis of the identity of its members. Membership implies a commitment to the domain, and therefore a shared competence distinguishes members from others.

The concept is clear.[40] An individual wishes to join a group engaged in a common activity—the practice of medicine or law—by learning how to carry out the activities in which the group is engaged. In doing so, the individual becomes a member of the group by moving from legitimate peripheral participation to full membership in the group. Their early membership is viewed as legitimate because they have been accepted as novice members of the community. Inherent in the move is the gradual acquisition of the required knowledge and skills, along with the identity of members of the group. This entails acceptance of the norms and values of the community and achieving competence within the domain, with the standards of competence being determined by the community. Learning is primarily a social activity and much of it occurs at the unconscious level, resulting in the acquisition of a large body of tacit knowledge. The learning is "situated" in the community and the content is given authenticity because it is acquired in the same context in which it is applied. Learner participation with members of the community is essential, as it allows each individual to recreate meaning, transforming knowledge from the abstract and theoretical into something personal and unique.

VI. PROFESSIONAL IDENTITY AND ITS FORMATION

The change in emphasis has resulted due to the recognition by medical educators that an individual's identity begins to emerge at birth and proceeds in stages throughout life, the period beginning in the late teens and stretching into early adulthood being particularly important.[41] The pro-

39. LAVE & WENGER, *supra* note 37.

40. *See* Cruess, *Reframing Education*, *supra* note 34; LAVE & WENGER, *supra* note 37; Cruess, *Schematic Representation*, *supra* note 38; LEARNING IN A LANDSCAPE OF PRACTICE (Etienne Wenger-Trayner et al. eds., 2015); David M. Kaufman & Karen V. Mann, *Teaching and Learning in Medical Education: How Theory Can Inform Practice*, *in* UNDERSTANDING MEDICAL EDUCATION: EVIDENCE, THEORY, AND PRACTICE 7-29 (Tim Swanwick ed., 2010).

41. *See* Monrouxe, *supra* note 31; Goldie, *supra* note 31; Jarvis-Selinger, *supra* note 31; Cruess, *Reframing Education*, *supra* note 34.

cess of professional education in both medicine and the law is superimposed upon this normal development and has a profound impact on the identities that emerge. Figure 3 offers a schematic representation of the process that has been termed socialization.[42] The assumption is that understanding the nature of a professional identity, the factors that influence its formation, and the process of socialization will lead to curricula built around supporting identity formation that are more "fit for purpose."

Professional identity is different from professionalism. Professionalism has been defined as "a set of values, behaviors, and relationships that underpins the trust the public has in doctors" or lawyers.[43] Professional identity is "a representation of self, achieved in stages over time during which the characteristics, values, and norms of the medical profession are internalized, resulting in an individual thinking, acting, and feeling like a physician."[44] This identity is not only how an individual is perceived by others but how each individual perceives their own "self."[45]

Socialization, the process through which identities are formed, is "the process by which a person learns to function within a particular society or group by internalizing its values and norms."[46] This involves the melding of knowledge and skills with an actual altered sense of self.[47] The schematic representation (Figure 3) outlines the process. Individuals, at a particularly formative stage of their lives, enter medical or law school with pre-existing identities that have been shaped by both nature and nurture. During the long period of undergraduate and (in medicine) postgraduate medical education, students must come to terms with the norms of the community of practice that they are entering. These norms are actually outlined in the definition of profession and professionalism as well as its list of characteristics or attributes.[48] Each learner must cope with these norms. Many will be accepted outright, some individuals will require some compromises, and some norms may be rejected. The current emphasis on lifestyle actually represents a collective rejection of previously accepted standards in medicine.[49] However, individuals must take

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42. *See* Cruess, *Schematic Representation*, *supra* note 38.

43. ROYAL COLLEGE OF PHYSICIANS, DOCTORS IN SOCIETY: MEDICAL PROFESSIONALISM IN A CHANGING WORLD 14 (2005) (Report of a Working Party of the Royal College of Physicians of London).

44. Cruess, *Reframing Education*, *supra* note 34, at 1447.

45. *See* Monrouxe, *supra* note 31; Goldie, *supra* note 31.

46. *Socialization*, OXFORD ENGLISH DICTIONARY (2d ed. 1989).

47. *See* Hafferty, *supra* note 30.

48. *See* Cruess, *Reframing Education*, *supra* note 34.

49. *See* Brainard & Brislen, *supra* note 26.

care. Outright rejection of many of the core standards of the profession can result in an individual being either marginalized or rejected by the community.[50]

Each individual emerges from each stage of the educational process with an altered identity that contains elements of "who they were" and "who they have become." Within medicine's educational community, there is a strong feeling that individuals must be able to remain "themselves" as they acquire professional identities, retaining core elements of their personalities.[51]

VII. FACTORS INFLUENCING IDENTITY FORMATION AND LEARNERS RESPONSES TO THE PROCESS

Figure 4[52] is an attempt to identify the major factors impacting socialization in medical education. Many, if not all, should apply to legal education. These, and the information contained in Figure 5,[53] have been analyzed in detail in previous publications and only a brief summary will be presented here.[54]

The major factors impacting identity formation in medicine are role models and mentors and both clinical and nonclinical experiences.[55] Both have a profound impact and work through conscious and unconscious mechanisms, leading to explicit and tacit knowledge.[56] Both are of course amenable to educational interventions that ensure that they have a positive impact on identity formation and are implemented in ways that are specific to the desired end result.

The foundational importance of reflection on the development of a professional identity cannot be overestimated.[57] Reflection on virtually any experience through the lens of communities of practice and identity formation can be of benefit and has been shown to be more effective when guided by a mentor and carried out as a group activity.

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50. *See* Hafferty, *supra* note 30, at 63.

51. *See* Monrouxe et al., *supra* note 31; Monrouxe, *supra* note 31; Heather D. Frost & Glenn Regehr, *"I AM a Doctor": Negotiating the Discourses of Standardization and Diversity in Professional Identity Construction*, 88 ACAD. MED. 1570 (2013).

52. *See* Cruess, *Schematic Representation*, *supra* note 38.

53. *Id.*

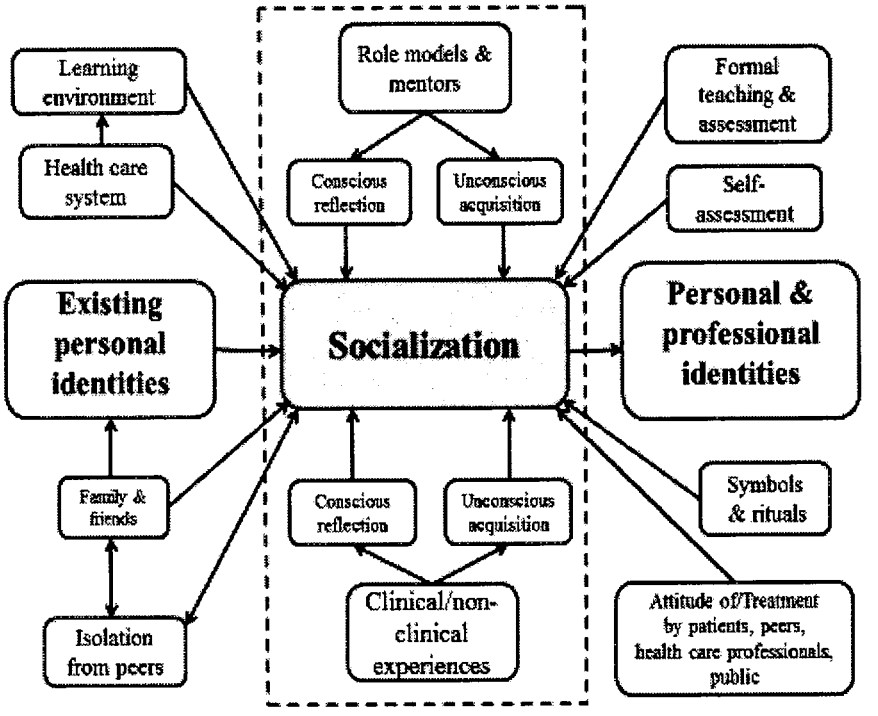
54. *See* Cruess, *Reframing Education*, *supra* note 34; Cruess, *Schematic Representation*, *supra* note 38.

55. *See* Kenny, *supra* note 7; Monrouxe, *supra* note 31; Burford, *supra* note 31; Goldie, *supra* note 31; Cruess, *Reframing Education*, *supra* note 34; LAVE & WENGER, *supra* note 37; LEARNING IN A LANDSCAPE OF PRACTICE, *supra* note 40.

56. *See* Epstein, *supra* note 25; Monrouxe, *supra* note 31; Cruess, *Reframing Education*, *supra* note 34.

57. *See* Epstein, *supra* note 25.

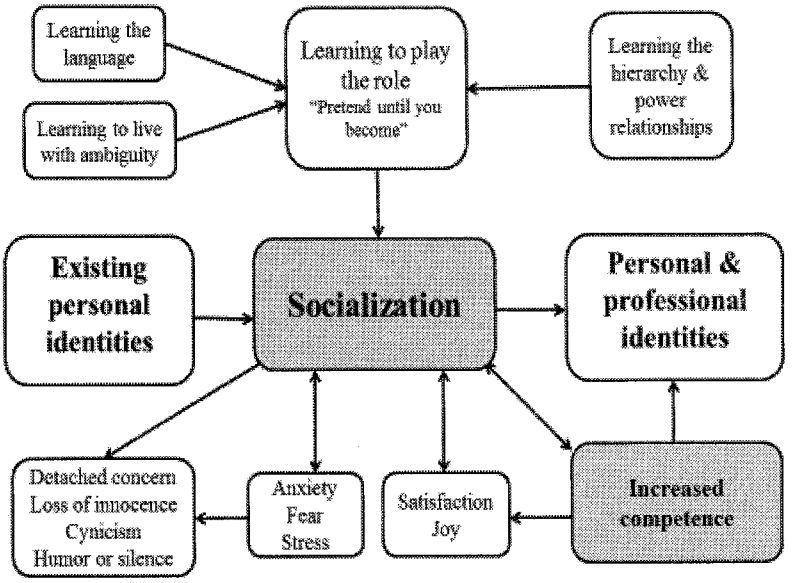
Figure 4



Of the multiple factors impacting on the process of socialization, role models and mentors, as well as both clinical and nonclinical experiences are the most powerful. However, there are other influences that depending on both the individual and circumstances, will play a significant role. Reprinted with permission by Academic Medicine, 2016.

Formal teaching of the cognitive base must be present, and the learning environment must be open, transparent, and welcoming. It is recognized that how individuals are treated by patients, family, and friends are also important. Isolation from peers appears to be inevitable in professional training and it actually serves to strengthen the sense of community. It is recognized that the nature of the healthcare system must impact on identity formation. It is not the task of medical education to alter health care systems, but learners must be aware of the impact of the system on who they become. Finally, assessment by each individual, assisted by a mentor or role model, of their progress towards the acquisition of a professional identity is important.

Figure 5



Learners must react to the process of socialization by exhibiting expected behaviors and by coming to understand the internal workings of medicine's community of practice. The result can be stress, joy, and increasing levels of competence. Reprinted with permission by Academic Medicine, 2016.

Figure 5 contains information drawn from the literature on the responses of learners to the process of socialization in medicine.[58] Of great importance is the fact that learners are expected to play the role of physician from a very early stage when they have neither the knowledge base nor experience to do so.[59] They therefore pretend, and continue to pretend, to play the role until they have actually acquired the identity of a physician. In the process of pretending, in addition to acquiring

58. *See* Cruess, *Schematic Representation*, *supra* note 38.

59. *See* Monrouxe, *supra* note 31; Cruess, *Reframing Education*, *supra* note 34.

knowledge and skills, they must learn the language of medicine, come to understand its internal hierarchy and power relationships, and realize the high degree of uncertainty involved in medical practice.

Altering one's identity involves either "suppression"[60] of the previous identity or a considerable degree of "identity dissonance"[61] as new aspects are merged onto an individual identity. This can lead to anxiety and fear, along with stress. However, this is diminished as competence and confidence increase, tending to stabilize a professional identity. Joy and satisfaction are also associated with increased competence.[62]

VIII. TRANSFORMING A CURRICULUM

For those institutions such as McGill University that have experience in teaching professionalism,[63] the reorganization of the curriculum to one devoted to supporting identity formation can benefit from the experience gained.[64] In the absence of such experience, it is nevertheless possible to institute such a comprehensive program, as has been accomplished for all six medical schools within the University of Texas system.[65]

In either case, an essential first step is the establishment of professional identity formation as a principal educational objective, and to do so publicly through an alteration of mission statements and so forth.[66] The preamble to the mission statement of McGill's Faculty of Medicine was changed to read as follows:

> A physician fulfils two roles in service to the patient: that of a healer and a professional. This is referred to as "Physicianship." Identity formation is an important goal of medical education; the program guides students in developing a coherent professional identity, assists them

60. ERIK H. ERIKSON, THE LIFE CYCLE COMPLETED (1982).

61. Monrouxe, *supra* note 31, at 42.

62. *See* Cruess, *Reframing Education*, *supra* note 34.

63. *See* J. Daniel Boudreau et al., *Physicianship: Educating for Professionalism in the Post-Flexnerian Era*, 54 PERSPECTIVES IN BIOLOGY & MED. 89 (2011).

64. *See* J. Donald Boudreau, *The Evolution of an Undergraduate Medical Program on Professionalism and Identity Formation*, *in* TEACHING MEDICAL PROFESSIONALISM: SUPPORTING THE DEVELOPMENT OF A PROFESSIONAL IDENTITY (Richard L. Cruess et al. eds., 2d ed. 2016).

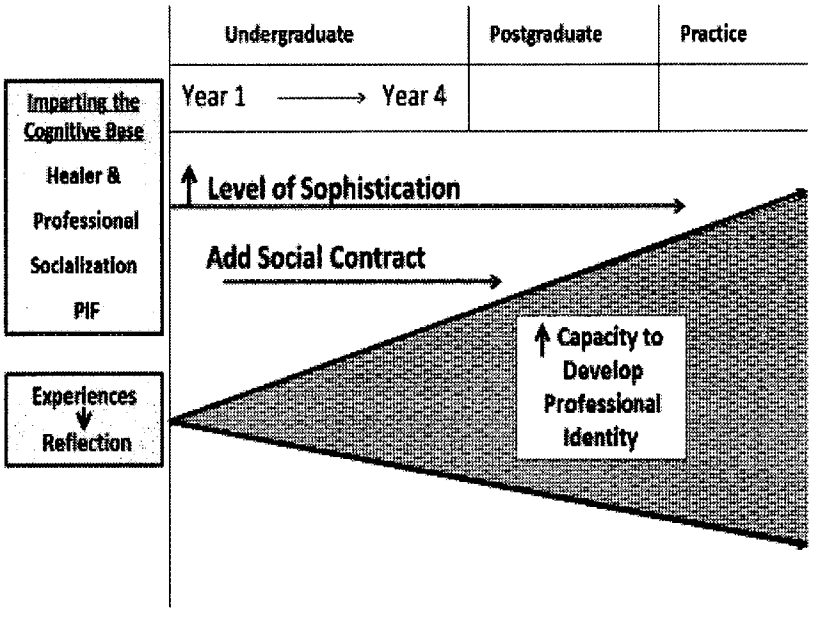
65. *See* Mark D. Holden et al., *Developing and Implementing an Undergraduate Curriculum*, *in* TEACHING MEDICAL PROFESSIONALISM: SUPPORTING THE DEVELOPMENT OF A PROFESSIONAL IDENTITY (Richard L. Cruess et al. eds., 2d ed. 2016).

66. *See* Sylvia Cruess & Richard Cruess, *General Principles for Establishing Programs Support Professionalism and Professional Identity Formation at the Undergraduate and Postgraduate Levels*, *in* TEACHING MEDICAL PROFESSIONALISM: SUPPORTING THE DEVELOPMENT OF A PROFESSIONAL IDENTITY (Richard L. Cruess et al. eds., 2d ed. 2016) [hereinafter Cruess, *General Principles*].

in understanding healer and professional roles and obligations, and supports them in retaining core aspects of their personal identities and values.[67]

Figure 6

Supporting Professional Identity Formation (PIF)



In reorienting a curriculum to support professional identity formation, both the cognitive base and the objective of the reflective exercises require modification.

67. FACULTY OF MEDICINE-MCGILL UNIVERSITY, Preamble, *Patient at Heart, Science in Hand* 2 (2015).

Figure 6, a modification of Figure 2, presents a schematic representation of the overall approach employed.[68] Once again the importance of the cognitive base cannot be overestimated. It has been expanded to include knowledge of the processes of socialization and professional identity formation. Time devoted to experiential learning and reflection has also been changed so that identity formation becomes the principal focus of the reflective exercises.[69]

A series of whole class and small group activities constitutes the program:

1. The first activity on the first day of medical school is an interactive introduction to the cognitive base of a program devoted to supporting identity formation: communities of practice, professionalism, professional identity formation and socialization. The schematic representations included in this article are given to learners for discussion. The class then breaks into small groups with trained group leaders, and each individual is encouraged to analyze their own identity and articulate the type of physician they wish to become.

2. Authentic clinical experiences with real patients begin in the first week of medical school, with each student assigned to a family practitioner. The emphasis once more is on identity formation, as experience has demonstrated that when an individual is functioning like a physician, even at a very early stage, professional identity is enhanced.[70]

3. There are regular whole class activities throughout the curriculum, with lectures always followed by small group discussions devoted to the physician as healer and professional seen through the lens of professional identity.

4. There are required reflective writing exercises devoted to identity formation throughout the clinical years.

5. A "White Coat Ceremony," common in medicine, takes place in which students "don the healer's habit," in the presence of their friends and family. This occurs at the end of the second year when students become fully engaged on the wards rather than in the classroom. This, along with the recitation of the Hippocratic Oath at the end of medical school, represent important symbols that have been shown to contribute significantly to the development of a professional identity.[71]

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68. *See* Cruess, *General Principles*, *supra* note 66.

69. *See* Boudreau, *supra* note 64.

70. *See* Monrouxe, *supra* note 31.

71. *Id.*; Monrouxe et al., *supra* note 31.

6. A mentorship program, present for many years, has been altered to focus on identity formation.[72] The mentors, called "Osler Fellows" after Sir William Osler, a McGill graduate recognized as probably the greatest of the modern physicians, are assigned a group of six students whom they will mentor throughout the four years of medical education. They have required and discretionary activities, meeting six times a year during the first two years of medical school and four times in the last two. They have a specific mandate to discuss progress towards a professional identity at regular intervals throughout the educational continuum. A published analysis of this program has shown that there is a profound impact, not only on the students, but on the Osler Fellows themselves who experience a renewed consciousness of and devotion to their own professional identities.[73]

7. Periods of transition can be stressful for learners as they move from one educational phase to another when their roles undergo substantial change. "Identity dissonance" appears to be a significant factor leading to stress.[74] There has been a movement within medicine to attempt to prepare medical students for these changes through courses designed to inform them of what will be required and how they may cope. The two major points in the curriculum where this has been found to occur are at the end of the second year when students are about to move to become clinical clerks working full-time with patients and just prior to graduation when they are contemplating the transformation to residency training.[75]

McGill University has instituted a two-day course at the end of second year and just prior to graduation. One day of these courses is devoted entirely to addressing the issue of identity formation and promoting reflection on the issues. Students are encouraged to think about their own progress, where they have been, where they wish to be, and what worries they have about the immediate future. The group leaders include more senior medical students, residents, other health care professionals, and of course faculty. While no data is of yet available on the impact of the courses, students and faculty feedback is enthusiastic.

8. All major educational initiatives require assessment of progress towards the educational goals and identity formation is no exception. During the period when professionalism was taught, methods of assessment

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72. *See* J. Donald Boudreau et al., *Affirming Professional Identities Through an Apprenticeship: Insights from a Four-Year Longitudinal Case Study*, 89 ACAD. MED. 1038 (2014).

73. *Id.*

74. *See* Monrouxe, *supra* note 31.

75. *Id.*

were developed in medicine in an attempt to assess the professional behaviors of students, residents, and faculty.[76] The emphasis was on observable behaviors that were either professional or unprofessional. McGill developed, and has used for some years, its own assessment tools for students and residents[77] and for student assessment of the professionalism of faculty members.[78]

Progress towards the acquisition of a professional identity can be measured, but the methods available are not yet feasible on a large scale.[79] Consequently, we have continued to assess observable professional behaviors and to use them as a surrogate for charting progress towards a professional identity. In addition, we ask our Osler Fellows, and other faculty members who have prolonged contact with individual students, to engage students in a program of self-assessment where they themselves reflect on where they are on the journey to becoming a physician. We encourage them to identify those factors that help them on the way and others that may inhibit progress. There is some evidence in the literature that this is a reasonable approach.[80]

IX. SUMMARY

The ultimate objective of medical education, as clearly articulated over fifty years ago by Merton, is not just to ensure that those entering the practice of medicine possess the knowledge and skills necessary for the task.[81] They should also be individuals whose behavior is professional because of who they have become. We have now come to understand that one way to achieve the desired objective that has been implicitly present since the dawn of medical education, is to specifically design educational programs that support individuals as they develop a professional identity necessary for the practice of medicine.

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76. *See* Wilkinson, *supra* note 27; Hodges, *supra* note 27.

77. *See* Richard L. Cruess et al., *The Professionalism Mini Evaluation Exercise: A Preliminary Investigation,* 81 ACAD. MED. S74 (2006).

78. *See* Meredith E. Young et al., *The Professionalism Assessment of Clinical Teachers (PACT): The Reliability and Validity of a Novel Tool to Evaluate Professional and Clinical Teaching Behaviors,* 19 ADVANCES HEALTH SCI. EDUC. 99 (2014).

79. *See* Richard L. Cruess et al., *Amending Miller's Triangle to Include Professional Identity Formation,* 91 ACADEMIC MED. 180 (2016).

80. *See* Muriel J. Bebeau & Kathy Faber-Langendoen, *Remediating Lapses in Professionalism, in* REMEDIATION IN MEDICAL EDUCATION: A MID-COURSE CORRECTION (Adina Kalet & Calvin L. Chou eds., 2014).

81. *See* Merton, *supra* note 35.

In closing, the following quote seems appropriate: "The central issue in learning is *becoming* a practitioner, not learning *about* practice."[82]

82. John B. Seeley & Paul Duguid, *Organizational Learning and Communities-of-Practice: Toward a Unified View of Working, Learning, and Innovation*, 2 ORG. SCI. 40, 48 (1991).