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## MEDICAL PROFESSIONALISM: TEACHING AND LEARNING

*The objective of modern education is to ensure that every physician understands the nature of professionalism, its characteristics, and the obligations necessary to sustain it. This can be considered as a cognitive base of professionalism. Teaching the cognitive base of professionalism is not difficult. Establishing the environment where the process of socialization in its most positive sense can take place is much harder. A scientifically competent medicine alone cannot help a patient grapple with the loss of health or find meaning in suffering. Along with professional skills, physicians need the ability to listen to patients and to act on their behalf. This is narrative competence, that is, the competence that human beings use to absorb, interpret, and respond to stories. This competency enables the physician to practice medicine with empathy, reflection, professionalism, and trustworthiness. Through systematic and rigorous training of such narrative skills as close reading, reflective writing, and authentic discourse with patients, medical students can improve their care of patients, commitment to their own health and fulfillment, care of their colleagues, and continued fidelity to medicine's ideals. Programs can be done to incorporate narrative work into many aspects of medical education and practice. It is time to stop focusing on the rule-based professionalism that dominates in our current teaching. Instead, we must acknowledge the narrative basis of medicine and develop educational experiences that will allow students and residents to learn what it truly means to be a physician. The assessment of professionalism must be subjective, narrative, personal, undertaken during both the periods of stress and during everyday activities (not just on special occasions).*

**Keywords:** medical professionalism, teaching, learning, curriculum, teaching methods.

### Introduction

*Medical Professionalism: (Professionalism and Professionalization in Medicine) Can It be taught?*

Recently a lot of attention has been devoted to the question of professionalism in medical education and practice. During last years, members of medical education community have devoted a great deal of time and efforts trying to ensure that medical professionalism is inculcated into medical students. So, many professional organizations, including AAMC, ABIM, ACGME, ACP, and AMA, have been holding special conferences dedicated to the issues of medical professionalism development. Regarding evidence, it is fair to say that the various aspects of medical professionalism, the ways of teaching and assessing it, have been discussed repeatedly within the medical education community and some efforts in this field have already been done. For instance, some exercises have been introduced into the curriculum that are focused on the development of students' professionalism, some assessment tools have been developed for distinguishing unprofessional and professional behavior, some ways have been established to orient students at their engagement into the medical profession (white coat ceremonies and taking Hippocratic Oath or its modern equivalent), etc. However, if students are not immersed in

clinical learning environments that embody the highest ideals of medical professionalism, it is likely that most of them will not become professionals. Of course, it is clear that establishing such clinical learning environments will be extremely difficult. However, reviewing the efforts made in order to study the feasibility of teaching professionalism in medicine and how to teach it increases the possibility of its achieving.

Thus, the article aims to explain the principles of medical professionalism and its development trends in medical education.

### Discussion

*Various views about teaching professionalism*

The issue of professionalism is relevant in medicine today, but teaching and evaluating professionalism are considered to be a difficult and ambiguous issue for medical educators (Coulehan, 2005). It seems that addressing the approaches in teaching professionalism can solve it. The literature indicates several approaches that must be considered if professionalism is to be taught effectively and internalized by students (Steinert, 2007). Various approaches related to medical professionalism have been offered. But it can be studied by two general approaches:

1. Explicit teaching and its development trend
2. Tacit teaching and its development trend

One contemporary school of thought has emphasized that professionalism needs to be taught explicitly, utilizing either definitions or outlining professionalism as a list of traits or characteristics (Cruss, 1997).

Some researchers studying the issue of professionalism believe that it should be taught explicitly because physicians with their continual failures have shown that they do not understand the requirements of contemporary professionalism (Irvine, 1997).

The objective of modern education is to ensure that every physician understands the nature of professionalism, its characteristics, and the obligations necessary to sustain it. This can be considered as a cognitive base of professionalism.

It is believed that teaching the cognitive base of professionalism and providing opportunities for the internalization of its values and behaviors are the cornerstones of the organization of the teaching of professionalism at all levels. Situated learning theory appears to provide practical guidance as the ways it may be implemented.

Maudsley and Strivens (2004) believe that among the available educational theories “Situating Learning Theory” seems to describe the most effective model to assist in the design of programs aimed at the transformation of students from members of the lay public (non-experts) to professionals with both appropriate skills and a commitment to a common set of values (Maudsley, 2004).

It is suggested that learning should be the basis of authentic activities which help to transform knowledge from abstract and theoretical to the useable and useful. Its proponents believe that there should be a balance between explicit teaching of a subject and activities in which the knowledge learned is used in authentic context (Cruss, 2006). Basing on the fact that behavioral and value-based aspects of clinical practice require special attention, one of the medical teaching institutions, McGill University, began to develop and implement the undergraduate curriculum of the Faculty of Medicine based on the “physicianship”.

“Physicianship” is not a common word in usage and its definition should be explained. For example, at McGill University it has acquired three meanings. It represents a unique vision of what may be considered as the essence of medicine’s mandate – that is, healing and the relief of suffering (Boudreau, 2011). It affirms that physicians assume dual roles, as healers and professionals, which should be taught explicitly, and it posits a set of behavioral attributes necessary for the fulfillment of each one (Boudreau, 2007). Finally, it refers to a specific curricular component comprised of a series of courses, including a longitudinal mentorship called “physician apprenticeship”.

An educational curriculum for teaching physicianship has been developed and deployed at McGill University (Boudreau, 2007). Again its direction and content are derived from the definitions and attributes of a healer and a professional. Imparting the cognitive base of both are important parts of the curriculum, as are the provision of

the stage-appropriate opportunities for experiential learning in both domains (Boudreau, 2008). The selected components of the program, including its approach to teaching clinical observation, skillful listening, and clinical thinking, also have been described (Boudreau, Cassell, 2011).

In 2005, McGill Physicianship program has designed a logo. One of its features, the word *phronesis*, has been a useful leitmotif for education. Phronesis, originating in Aristotelian philosophy, is often equated with *prudence* in English; it has been defined as “practical wisdom in dealing with particular individuals, specific problems and details of practical case or actual situations” (Boudreau, 2011). There is increasing recognition of the concept’s relevance to medical practice, most notably in bioethics and clinical reasoning (Boudreau, 2011). It has also been recently proposed as a guiding logic for educational initiatives in medical professional’s development.

Kinghorn (2010) argues that balances must be achieved between intellectual and moral excellence, cognitive and experiential learning, and theoretical and practical knowledge. Kinghorn’s recipe for fostering the acquisition of “phronesis” can be summarized as follows: recruit students of good moral character; teach and mentor them, relying on teachers of moral and clinical excellence; communicate the cognitive base for professionalism and link it to authentic clinical experiences; and provide an appropriately nurturing institutional culture. These four conditions are precisely what the physicianship program has endeavored to provide (Kinghorn, 2010).

The physician apprenticeship course is of fundamental importance in teaching Physicianship. It has been designed to address the socialization aspect – identity formation – of the medical education experience.

Hafferty (1998) has suggested that a student’s enculturation can be analyzed and understood at the level of formal and informal as well as “hidden” curriculum, the latter being highly reflective of an institution’s cultural ethos. While striving to achieve curricular objectives, adhering to institutional rules and professional conventions, attempting to forge meaningful relationships, students undergo a change at the core of their being. The enculturation begins rapidly, as early as they are enrolled in medical school (Hafferty, 1998).

At the center of this pedagogy is the idea that teaching and learning are about much more than transferring facts or even cognitive tools. Learning in the formative sense is a process by which the student acquires a certain kind of thinking, feeling and behavior (Foster, 2006). In the context of medical education, the transformative trajectory is from a lay person to a healer.

The maieutic tools used to meet these objectives are based on creative writing with the aim to develop narrative understanding (Boudreau, 2011).

Physicianship represents a unified approach to the education of future practitioners based on a core set of definitions of professionalism and healing and a list of desired attributes that are seen to permeate the entire

educational experience – from the admission of medical students, to their teaching and learning activities, and ultimately to the assessment of behaviors in teachers and learners (Boudreau, 2011).

Others have stated that the teaching of professionalism should be approached primarily as a moral endeavor, emphasizing altruism, and service, stressing the importance of role modeling, efforts to promote self-awareness, community service and other methods of acquiring experiential knowledge. Explicit teaching receives less attention (Coulehan, 2005; Hafferty, 2003). They seek to transform learning into authentic activity, emphasizing the usefulness of knowledge.

While it would be wrong to overemphasize the differences between these two approaches, they do exist. Teaching the cognitive base of professionalism is not difficult. Establishing the environment where the process of socialization in its most positive sense can take place is much harder. How this is best accomplished constitutes the main challenge to medical educators at the present time. Professionalism is fundamental to the process of socialization during which individuals acquire the values, attitudes, interests, skills, knowledge, and the culture of the group to which they want to belong (Hafferty, 2003).

The teaching of professionalism should be started with understanding that there is a cognitive base of professionalism which must be taught explicitly and then reinforced and internalized by the student through experiential learning. This requires a strong institutional commitment to supporting the teaching program throughout the educational process. This issue is of importance to both medicine and society, as “medical professionalism lies at the heart of being a good doctor” (Royal College of Physicians of London, 2005).

The cognitive base needs to be defined and communicated to all physicians to make them understand the nature of professionalism, its relationship to medicine’s social contract with the society, and the obligations necessary to sustain professionalism. Moreover, in order to promote self-reflection/ awareness (Hilton, 2005) and enhance «mindfulness», opportunities should be provided for experiential learning on a regular base, so that professionalism does not remain just a theoretical or marginal concept. Professional identity is formed through the combination experience and informed reflection on experience (Rudy, 2001; Coulehan, 2005; Huddlem 2005). Accordingly, inspired by Aristotle, Hilton and Slotnick (2005) propose the concept of *phronesis*. Aristotle (in Nicomachean ethics) referred to practical wisdom – arguable a “sine qua non” of the mature professional in action – *phronesis*. *Phronesis* arises from 2 components – experience and reflection on experience – interacting with the professionals’ evolving knowledge and skills base. Professionalism is thus a state reached only after a long period of learning, instruction, and reflective experience. In terms of this it is necessary to dwell upon so-called proto-professionalism (Hilton, 2005). From the perspective of the learner proto-professionalism is about developing

*identity* (i.e. what a person does and this person’s attitude towards others). This is in turn, a function of knowledge and skills gained from learning and experience and the *phronesis* arising from reflection on that experience. The professional’s identity development is a product of 2 simultaneous processes: attainment and attrition. The educational and work environment shape acquisition and maintenance in positive (attainment) and negative (attrition) ways.

Attainment is about positive influences, ranging from curriculum design to clinical environment. Lave and Wenger refer to learning occupations having learners starting at the periphery and working toward the center (Hilton, 2005). This movement from periphery to centrality carries with it different “identities”. At each stage, learner’s actions and interactions provide experiences and offer opportunities to reflect. These things do not constitute professionalism but address learners’ immediate psychosocial needs, and they are necessary for professionalism in the future (Fraser, 2001).

Attrition results from adverse effects of the environment, such as unhelpful teaching approaches in medical schools or harshness in the complex adaptive healthcare systems in which medical students and doctors work.

Arguably, the pressure created in these environments have the most significant influence on the character of professionalism exhibited by the mature practitioner. Important influences of the hidden curriculum may convert the naive idealist entering a system to a cynic (Hafferty, 2001).

Approaches to learning are acquired early in training and shape the learner’s identity (Slotnick, 2001) and that proto-professionals need explicit rather than implicit attention to 6 suggested domains of professionalism throughout training. These 6 domains may be classified as those areas focusing on the doctor alone (ethical practice, reflection and responsibility), and those requiring collaboration (respect for patients, teamwork and social responsibility). It is necessary to discuss details of content and the assessments that should underpin it across the medical education continuum. But it is much more necessary to increase attention given to the development of meta-skills, such as reflection (Driessen, 2003). It is suggested to reconsider the under-emphasized areas in primary medical degrees.

We do not denigrate science, objectivity, specialism and so forth, they all are essential for good medical professionalism. However, a more evident balance is proposed and taking these actions will foster professionalization from the earliest opportunities. Once acquired, medical professionalism must be maintained – it is a state, not a trait. Approaches to licensure and relicensure are recognizing this increasingly (Hilton, 2005).

Tacit learning includes learning and socialization processes without explicitly explaining those issues. This hidden curriculum continues throughout medical training. While the explicit curriculum is focused on empathy, communication, relief of suffering, trust, fidelity, and pur-

suing the patient's best interest, in the hospital and clinic environment these values are largely pushed aside by the tacit learning of objectivity, detachment, self-interest, and distrust – of emotions, patients, insurance companies, administrators, and the state (Coulehan, 2005).

There is often a “hidden curriculum” that is present in many medical institutions that must be extinguished. It embraces values of efficiency and impersonality that are in conflict with professed values and threaten professionalism (Indyk, 2011).

Chief concern with medical education should be focused on the third curriculum – the silent, covert, sub-rosa curriculum that is referred to as the “hidden curriculum”. It is a set of influences that work at the level of an organization to define the organizational and professional culture. These learning events are unscripted, often unplanned and usually deliver unintended messages that are conveyed by different people at different levels on the medical hierarchy – the faculty, the residents, the nurses, and others. Through observation and modeling of health providers, students acquire behaviors and traditions that they are likely to adapt and model and eventually pass on to others as they move from students to teachers. The growing complexity of contemporary healthcare system, medicine evolving into a trade, fiscal deficit, human resource shortage, the behavior of some physicians and medical institutions, generation gaps and increased conflicts of interest are threatening factors for traditional value systems of medicine profession (Bodreaou, 2011).

Wilkes (2015) writes: “We lecture and will lecture our students. We talk about sensitivity, ethics, professionalism, and cultural awareness. But how we behave and how we serve as role models is what is learned, remembered and practiced. Substantial student learning takes place outside of formal learning environments instead occurring in operating room waiting areas, elevators, hallways and cafeterias. Planning and developing of what has been hidden in the curriculum to make it explicit and visible requires a culture of openness and self-reflection. It requires a multidisciplinary perspective and teamwork. It also requires that people from the community move from being our “patients” to being our partners and planners and advisors” (Mitchell, 2015).

Coulehan and Williams (2001) have argued that the conflict between tacit and explicit values seriously distorts the development of medical professionalism in students. At the experiential level, medical students and house officers attempt to relieve or resolve their internal conflict by adopting one of three styles of professional identity: technical professional identity; non-reflective professional identity; and compassionate and responsive one (Coulehan, 2001).

These characterizations represent the physician's internalization of what being a good doctor means and the manner in which he or she should behave. Coulehan and Williams (2003) claim that a large percentage of graduates are best characterized as non-reflective professionals; that is, physicians who believe that they embody

virtues like fidelity, self-effacement, integrity, compassion, and so forth, while acting in ways that not only in conflict with these virtues, but also contribute to contemporary problems in health care such as rising costs, inadequate physician-patient communication, and widespread dissatisfaction. It is this group of physicians that most clearly exemplifies (Coulehan, 2003) Albert Jonsen's insight about the core dynamic of professionalism, “The central paradox in medicine is the tension between self-interest and altruism” (Coulehan, 2005)

Thomas Inui's report, “A Flag in the Wind: Educating for Professionalism in Medicine,” which is based on his experience as scholar-in-residence at the AAMC, presents a systematic and comprehensive analysis of their continued failure to instill professional virtue in medical education. Inui's eight conclusions (2003) are parallel to Coulehan's (2005) argument.

To nurture the professional virtue, or narrative-based professionalism, Inui (2003) observes that “we will actually have to change our behaviors, our institutions, and ourselves” (Inui, 2003). Coulehan (2005) believes that in the educational culture, the prospects for such change seem bleak; yet he believes that cultural change is possible, given the right catalyst and sufficient receptivity in the medical community. He believes that receptivity among medical educators is growing, given their dissatisfaction with the processes and products of professionalism education. As to the right catalyst, he suggests four interrelated educational requirements that could provide a basis for the formation of a new medical morality in the 21<sup>st</sup> century. In proposing this framework, he is drawing upon the ideas of others, especially his colleagues in the fields of reflective practice and narrative medicine. Moreover, as a means of evaluating a trainee's performance as he or she progresses through the process of learning professional virtue, he proposed another borrowed idea, the educational portfolio.

Coulehan (2005) argues that today's culture of medicine is hostile to altruism, compassion, integrity, fidelity, self-effacement, and other traditional qualities. Hospital culture and the narratives that support it often embody a set of professional qualities that are diametrically opposed to virtues that are explicitly taught as constituting the “good” doctor. Young physicians experience internal conflict as they try to reconcile the explicit and covert curricula, and they often develop non-reflective professionalism. Additional courses on professionalism are unlikely to alter this process. Instead, Coulehan proposes a more comprehensive approach to changing the culture of medical education namely to narrative-based professionalism to deal with the tension between self-interest and altruism. Coulehan argues that in order to mold the professional behavior of physicians-in-training, a meta-narrative should be used. It has developed over 2,500 years as a summation of many thousands actual physicians' stories from different times and cultures. Trainees must also experience professionalism as a bundle of contemporary narratives, either observed directly through

role-model physicians and other health professionals, or indirectly through stories and films. In other words, in order to acquire professionalism one should enter a certain kind of narrative and make it one's own. He uses the term "narrative-based professionalism" to refer to this tradition, contrasting it with rule-based professionalism. This approach involves four specific catalysts: professionalism role-modeling, self-awareness, narrative competence, and community service (Coulehan, 2005).

Professionalism was traditionally transmitted from one generation to another by respected role models (Crues, 1997). It is believed that this method was successful, in part, because the medical profession was fairly homogeneous and, despite some generational differences, shared values were the norm. In today's complex and diverse society, one can no longer assume the common values as there are new challenges to the traditional values of the medical profession posed by modern health care systems. It has therefore been concluded that role modeling, while remaining a powerful and essential tool, is no longer sufficient (Ludmerer, 1999; Wright, 2001).

**Self-awareness:** the second prerequisite for developing narrative professionalism is to provide a safe venue for students and residents to share experiences and enhance personal awareness. Doctors need to understand their own beliefs, feelings, attitudes, and response patterns.

**Narrative competency:** medical practice is structured around narrative. However, as a result of the tension between explicit and tacit values, even though medicine is a narrative-rich environment, students learn to objectify their patients and devalue the subjective. Therefore, the third prerequisite for developing narrative professionalism is "the ability to acknowledge, absorb, interpret, and act on the stories and plight of others".

A scientifically competent medicine alone cannot help a patient grapple with the loss of health or find meaning in suffering. Along with professional skills, physicians need the ability to listen to patients and to put themselves in patients' place. This is narrative competence, that is, the competence that human beings use to absorb, interpret, and respond to stories. This competency enables the physician to practice medicine with empathy, reflection, professionalism, and trustworthiness. It can be called narrative medicine (Charon, 2001).

Perhaps the most effective methods to strengthen professionalism in medicine are to endow physicians with the competence required to fulfill their narrative duties towards one another.

When sociologists studied medicine in the 1960s, they observed physicians to practice medicine with "de-

tached concern". Somehow, this observation has become a norm, and physicians for decades seemed to consider detachment as a goal. Today, relying on newly emerging knowledge from narrative disciplines, physicians are learning to practice medicine with not detached but engaged concern, an approach that requires disciplined and steady reflection on one's practice.

As reflective practitioners, physicians have turned to a study of the humanities, especially literature, to grow in their personal understanding of illness. Literature seminars and reading groups have become common in medical schools and hospitals. Narrative writing by students and physicians has become a staple in many medical schools and hospitals to strengthen reflection, self-awareness, and the adoption of patients' perspectives (Charon, 2001).

Through systematic and rigorous training of such narrative skills as close reading, reflective writing, and authentic discourse with patients, medical students can improve their care of patients, commitment to their own health and fulfillment, care of their colleagues, and continued fidelity to medicine's ideals. Programs can be done to incorporate narrative work into many aspects of medical education and practice. The teaching of literature in medical schools has become widely accepted as a primary means to teach about the patient's experience and the physician's interior development (Charon, 2001).

**Community service:** finally, to instill professional values, the medical curriculum must include socially relevant service-oriented learning.

Service-oriented learning works in very different geographical and societal levels; it includes all activities done locally, nationally, and internationally (Coulehan, 2005).

### Conclusions

There is a great deal of work yet to be done. In particular, in trying to foster professionalism, very little progress has been made in addressing a fundamental issue: the nature of the clinical environment in which students and residents learn medicine. But scholars now start discussing the inadequacies of the approaches being used for inculcation professionalism into students.

Medical education must be changed if the ideals of medical professionalism are to be inculcated into future practitioners.

It is time to stop focusing on the rule-based professionalism that dominates in our current teaching. Instead, we must acknowledge the narrative basis of medicine and develop educational experiences that will allow students and residents to learn what it truly means to be a physician.

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### **ОСОБЛИВОСТІ ФОРМУВАННЯ МЕДИЧНОГО ПРОФЕСІОНАЛІЗМУ СТУДЕНТІВ-МЕДИКІВ**

Одним з аспектів сучасної медичної освіти є забезпечення розуміння кожним лікарем природи професіоналізму, його характерних рис, а також умов, необхідних для його набуття та підтримки. Навчання студентів когнітивної бази професіоналізму не є складним. Набагато складнішим є створення умов, за яких знання студентів можуть бути перевірені на практиці, а також за яких міг би відбутися повноцінний процес їхньої соціалізації. Теоретичні знання з медицини не можуть допомогти пацієнту боротися зі втратою здоров'я. Тому, поряд з професійними навичками, лікарі повинні вміти прислухатися до пацієнта, співчувати йому та вживатися в його роль, щоб допомогти. Йдеться про так звану наративну компетентність, яка допомагає людині сприймати, інтерпретувати та реагувати на певне явище. Вона дозволяє лікарю запроваджувати у свою медичну практику риси емпатії, рефлексії, професіоналізму і надійності. За допомогою систематичного розвитку наративних навичок (шляхом уважного читання, написання самокритичних есе (в яких студенти розглядають себе як майбутніх фахівців та оцінюють свої професійні якості), а також бесід з пацієнтами) студенти-медики можуть урізноманітнити та поліпшити свої навички догляду за пацієнтами, покращити взаємодію з колегами, набутти нових знань тощо. Час відходити від традиційного підходу в медицині, в якому домінує принцип «відстороненості». Замість цього медична практика має будуватися на наративному підході, який слід запроваджувати в освітній процес, що дозволить студентам-медикам зрозуміти, що в дійсності означає бути лікарем. Насамкінець варто зауважити, що оцінювання професіоналізму має бути об'єктивним, особистісним та відбуватися як у стресових ситуаціях, так і в повсякденній професійній практиці студента/лікаря.

**Ключові слова:** методи, медичний професіоналізм, викладання, навчання, навчальний план, освіта.

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