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Family Medicine

PRESIDENT'S COLUMN

We Need Cats: A New Professionalism for a Broken System

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STFM's 2025-29 Strategic Plan[1] has a tactic to "Develop curriculum for teaching and assessing professionalism that is challenged by changes in technology, market forces, and health care delivery systems." This month I will discuss why our board of directors believes this is such an important topic for all who teach family medicine. Next month's President's Column will focus on how to teach and assess professionalism that takes into account changes in the health care and societal landscape that now threatens professionalism.

The Accreditation Council for Graduate Medical Education's Common Program Requirements section on Professionalism[2] implicitly conveys an overriding concern about residents working in clinical environments that threaten wellness that in turn threatens professionalism. Notably, this section is approximately 700 words in length while the next section on well-being, fatigue mitigation, clinical responsibilities, teamwork, and duty hours has over 3,000 words. A renewed emphasis and redefining of professionalism could be the missing ingredient to produce true wellness, rather than focusing primarily on workplace regulation.

Along these lines, Frederic Hafferty and colleagues[3] asked a series of questions to faculty and student attendees at the 2016 Alpha Omega Alpha conference on medical professionalism. Respondents overwhelmingly agreed that the medical industrial complex was a threat to professionalism. Hafferty then asked whether we are educating medical students today more as sheep ("perfect followers") or like cats ("independent beyond belief") at each end of a spectrum scale. Results were widely distributed. He then asked first-year medical students to imagine their future selves as physicians and whether becoming a physician is more like being trained as a *Star Wars* Clone Trooper ("hired gun and bounty hunter with unquestioning service to the emperor") or as a Jedi Knight ("a wise sage with special fighting powers whose group identity and training both serve, and when necessary, question the emperor for the sake of a higher good [The Force]." Most first-year students aspired to be Jedi Knights. To close, he asked whether professionalism is about conformity ("following the rules") or courage ("challenging authority and power"). Many more respondents saw the term "professionalism" as being about conformity and following the rules rather than about courage and challenging authority when needed.

Summary quotes included, "Knights are noble. Clones protect vested interests," "Are physicians loose cannons in need of controlling or are they helpless and hapless pawns of management?" "Is medicine a culture of cats or sheep?" Hafferty identified four key issues. Conference attendees (1) viewed the medical industrial complex as a continued threat to the profession of medicine and to physicians as professionals; (2) attendees viewed medical schools as some combination of sheep farm and cat-producing enterprise; (3) first-year medical students viewed professionalism as being about rules and rule following that produced Clone Troopers even as they want to become Jedi Knights; and (4) students viewed professionalism as more about conformity than resistance.

Traditional professionalism training and residency teaching can be viewed as "professionalism-lite" with most of the focus on dress codes and personal appearance, punctuality, substance use/impairment affecting the job, social media use, and completing required tasks (eg, charts being done on time). Most of these topics pertain to any job rather than distinguishing a professional. Boundary issues are often discussed primarily from a human resources perspective focusing on sexual harassment in the workplace. It is unclear how often consensual professional boundary issues between faculty, residents, students, and patients are explicitly discussed in the context of power dynamics. Professional development including outside reading and achieving and maintaining competency are often not clearly articulated as a professionalism imperative and may even be considered counter-wellness.

Professionalism has often devolved into separating the bad apples from the good ones; there are certainly bad ones who require attention for the public's good. For all others, the reality is that the public currently has access to only bruised

apples who are generally doing their best in a broken system. System change calls for a different approach. Creating a new understanding of professionalism is not about blaming and shaming family physicians or our learners.

Professionalism has often been weaponized by employing institutions, and physicians and nurses have been exploited in the name of professionalism.[4] This was seen very readily during the early stages of the COVID-19 pandemic when physicians were asked to see patients without adequate protection and required to care for too many patients for too many hours with professionalism invoked to justify this. When the pandemic abated those same institutions quickly viewed physicians as employees again without a higher responsibility beyond their employer.

Wellness has also been weaponized. At a recent American Board of Family Medicine retreat on professionalism, a resident focus group including several chief residents responsible for patient coverage told stories of some residents in their programs consistently stepping up to cover for a colleague and others never doing so, citing wellness as the reason for their repeatedly declining requests.

Lapses of professionalism, as typically taught, are primarily actions at a level that will get a physician in trouble with the state medical board or specialty board. These include fraud and criminal actions, boundary violations (including inappropriate relationships with patients), professional incompetence, inappropriate prescribing of controlled substances, and impairment. However, physicians are now practicing in a more difficult practice environment as employees of larger corporate entities with increased productivity expectations, greater administrative burden, and insurer/employer insertion into physician decision making. There are now four entities in every exam room—the patient, the physician, the patient's insurer, and the physician's employer. The environment is a set up for cutting corners to get by as a survival mechanism, addressing competing goods and navigating divided loyalties more than in the past. We clearly need to surface these issues in training so professionalism does not die of a thousand cuts.

Each day in family medicine practices, small acts of patient centeredness and patient advocacy occur with little fanfare. In residency training, these "microacts"[5] need to be positively reinforced and identified for proper role modeling. Microacts are often the converses of "microlapses." Examples include making the extra phone call or going the extra mile for a patient, taking actions that support continuity and relationship-based care such as volunteering to see a continuity patient outside the schedule, and doing team building and team supportive acts. These small, meaningful acts of kindness need be reinforced and discussed while working to improve the clinic or hospital team's practice and the wider system, so as not to rely solely on random heroic acts of patient advocacy.

Some examples of microlapses that occur as a means to "get by" include referring to a specialist prior to an adequate workup because it is faster and easier; not ordering the most beneficial drug for a patient to avoid prior authorization paperwork; or prioritizing clinical measures over patient needs during a visit because of financial or quality indicator implications. Within team-based care, not taking ownership and delaying needed treatment changes for someone else to do; having a rigid 9 to 5 approach; prescribing influenced by pharmaceutical representatives; and inappropriately limiting patient concerns addressed within an office visit are some failures of beneficence. Inadequately shared decision making for cancer screening, disrespecting patients with addictions or other conditions, or ordering a test or procedure without discussion of potential consequences are all microlapses of not respecting autonomy. Microlapses concerning nonmaleficence include providing overly generous school/work notes or writing prescriptions to improve patient satisfaction scores or avoid conflict, not completing patient charts in a timely manner, and documenting review of systems and physical exam findings that were not done. Microlapses of lack of justice include embellishing prior approval or medical equipment paperwork, cherry picking or lemon dropping patients to improve quality measures, writing unjustified letters to airlines for travel with comfort animals, and overprescribing of antibiotics contributing to community drug resistance.

There is now a call for members of a new STFM Professionalism in Medical Education Task Force[6] to modernize how family medicine defines, teaches, and assesses professionalism given major changes in the health care environment. The deadline for applying to be a member of this task force is March 20, 2025. I hope you'll consider applying.

Freedom is greatest when boundaries are clearly defined. Having well-defined limits and family medicine-derived expectations of a new professionalism will allow for greater physician autonomy for patient benefit. In a team-based practice environment we do need to row in the same direction, we do need to generally comply with organizational rules, and we do need to choose our battles. However, we also need to teach faculty, residents, and students when, as a practicing physician, they must act as cats and not sheep, as Jedi Knights and not Clone Troopers, and when they must draw on their courage to fulfill their responsibility to their patient and to the public.

If we do this well, professionalism can be a major countervailing force to a corporatized, profiteering, non-patient-centric, transactional system. Developing a covenant outlining our responsibilities as professionals that supersede our responsibilities as compliant employees will best serve our patients.

Knowing how and when to effectively and selectively challenge authority, whether employers, insurers, or inhumane governmental edicts, is the professional thing to do.

REFERENCES

1. STFM Strategic Plan. *Society of Teachers of Family Medicine.* 2025. https://www.stfm.org/media/ajqptskr/2025-2029-strategic-plan.pdf.
2. ACGME Program Requirements for Graduate Medical Education in Family Medicine. Section VI.B. 2023. *Accreditation Council for*

Graduate Medical Education. 2024. https://www.acgme.org/globalassets/pfassets/programrequirements/120_familymedicine_2024.pdf.
3. Hafferty FW, Michalec B, Martimianakis MA, Tilburt JC. Resistance and radicalization: retraining professionals for the modern era, In: RL B, DS P, M P, S P, eds. Medical Professionalism Best Practices: Professionalism in the Modern Era. Alpha Omega Alpha Honor Medical Society; 2017:59-72. https://www.alphaomegaalpha.org/wp-content/uploads/2022/01/Monograph2018.pdf.
4. Ofri D. The business of health care depends on exploiting doctors and nurses. *The New York Times.* June 8, 2019. https://www.nytimes.com/2019/06/08/opinion/sunday/hospitals-doctors-nurses-burnout.html.
5. Gravel JW. Professionalism in an era of corporate medicine: addressing microlapses and promoting microacts as a new model. *Fam Med.* 2021;53(7):535-539.
6. Call for Members of a Professionalism in Medical Education Task Force. *STFM News.* 2025. https://www.stfm.org/news/2025-news/020725-call-for-members-of-a-professionalism-in-medical-education-task-force/.