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Family Medicine

PRESIDENT'S COLUMN

Teaching and Assessing a New Professionalism: The Journey Begins

Joseph W. Gravel Jr, MD

AUTHOR AFFILIATION:

Medical College of Wisconsin Department of Family and Community Medicine, Milwaukee, WI

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Last month's President's Column[1] discussed why significant changes in the health care environment require a new model of professionalism. As was mentioned, STFM is creating a task force on professionalism in family medicine education that will initially meet this July and actively work on this (and present its outputs) for several years. The project lead is Mary Theobald, MBA, STFM's chief of strategy and innovation. We anticipate the work of the task force will include curriculum development, a plan for developing new faculty development materials in how to best teach professionalism, recorded webinars, presentations at numerous conferences, and aggregated professionalism resources on the STFM website. We also hope to identify existing competency-based assessment tools and create new ones during this process. The task force will produce a final report that will be useful to family medicine educators.

As we embark on this journey, we understand that residency and medical student education is challenged by limited faculty time to initiate curricular change, and that professionalism is a term that has taken on negative connotations. We must effectively communicate to all that this initiative is intended to update the concept of professionalism training with new expectations and tools rather than simply restating and endorsing traditional training for this important competency. When developing our deliverables, we will take into account considerations including change fatigue; significant clinical organizational consolidation in which the nidus of control is often far remote from the teaching environment; and the current turbulent governmental milieu that currently threatens our clinical, research, community engagement, and educational missions. This column will focus on some initial thoughts on how to best teach an updated concept of professionalism. The collective wisdom of this task force and the larger family medicine educator community's feedback will certainly far surpass these preliminary ideas.

The task of professional identity formation is often one of idealism colliding with the realities of health care environments. The task force will utilize resident and student focus groups to ensure multigenerational input and perspectives. They will be asked how they perceive the current state of professionalism, their challenges, what curricula should include, and their perception of faculty development needs. Any tools developed need to be user friendly for faculty but also seen as useful by learners.

Like most topics, teaching professionalism in residencies and medical school should emphasize active learning techniques. Using activities like case discussions, debates, simulations, and/or role-playing will encourage engagement and active critical thinking. Some key educational platforms could include Balint-like groups led by a family medicine faculty member, starting each session with a specific case. These cases can be gleaned from faculty precepting sessions or volunteered by residents and students. Active precepting can surface in-the-moment professionalism dilemmas arising from the dual agency of current practice in which the physician faces conflicting obligations in simultaneously serving the interests of both the patient and the employing institution or system.

Whether all levels of advocacy are a professional responsibility or not (as stated in the advocacy milestones), and why or why not, should be explicitly discussed. Advocacy to provide access to needed services for an individual patient can be connected to considering the need for governmental advocacy systemically. Practice-level advocacy within the organization can include giving guidance on effectively raising issues with institutional leadership and teaching about how the flow of funds to and from the residency practice often drive local policies. Working directly with a community-based organization could be a standard part of each resident's required experience. Teaching about the family physician's role in public health and health policy through family medicine organizations (eg, AAFP state chapters) and other organizations with health-related impact in areas of special interest to the learner (eg, climate

change) could be made experiential.

Residency orientation is a special opportunity to discuss professionalism with newly credentialed members of the profession who are learning how the residency practice and hospital actually work in the real world, building on a strong medical school conceptual foundation. Potential residency activities during orientation must include "professionalism lite" topics that can be found in any job orientation, including dress codes, accurate reporting of work hours, supporting safe work environments, implicit bias training, and social media training. Residents can be introduced at orientation to terminology such as microacts, macrolapses, and microlapses as described in last month's column.[2] Professionalism, however, needs to be defined as an aspirational concept. This includes nurturing an intrinsic desire for personal growth and lifelong learning and reflecting on medicine as a calling.

Two other topics related to professionalism would be helpful to cover during residency orientation. Understanding the origins and history of the specialty of family medicine as a reform movement of the US health care system would provide context for a values-driven and socially-aware approach to the work. This would include understanding the intellectual basis of generalism and why family medicine is countercultural to the transactional care promulgated by unfettered corporatization, consolidation, consumerism, and commercialization. The second is a simple act of explaining to residents why the program does not endorse use of the insurance industry term "provider"[3] to label them, and that this term neither accurately nor appropriately describes a professional whom patients entrust with their lives and those of their family members.

Possible residency activities include precepting sessions (including some direct-observation video evaluations) with specific professionalism microact and microlapse items assessed. A standing agenda item in residency practice business meetings could include identifying and discussing practice or health care system-generated or facilitated microacts and microlapses. Practice policies and operations such as the late patient policy and payer mix-driven directives should be discussed within the framework of professionalism.

A specific faculty member could be designated to lead the professionalism curriculum, including faculty development sessions and implementing assessment tools. If it is everyone's job it often becomes no one's job. Residents could receive training in the use and misuse of clinical measures and their positive and negative effects on professionalism, and the teaching practice could implement comprehensive primary care-oriented measures such as the Person-Centered Primary Care Measure (PCPCM).[4]

Most importantly of all, daily faculty role modeling is crucial. The unwritten curriculum must align with the written one. Although faculty role modeling occurs in a difficult clinical education environment, residents and students need to see faculty doing microacts consistently and avoiding microlapses—or at least being cognizant when they occur. Shadowing sessions of selected faculty to surface microacts and discuss microlapse near misses could be helpful. Explicit faculty development for teaching and assessing professionalism using this new model is needed.

We also will be working closely with our colleagues from the American Board of Family Medicine in this space. I look forward to our STFM Professionalism in Family Medicine Education Task Force[5] and reporting to you what we develop for your input. The journey begins!

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