ries of rules, and it suggests that doing so is part of becoming what they had not been. “Think what you will about morality; here is what doctors do.”

We in no way wish to deny that the distinctive role of the physician creates distinctive moral challenges. Medical ethics education that gives priority to the development of good ethical deliberation over the imparting of moral truths can, in fact, give medical students and professionals the tools they need to work through many concerns in professionalism. What is called for by many medical educators who have accepted the centrality of professionalism, however, is not this kind of education at all, but instead, the accomplishment of two tasks: introducing students and residents to “professional standards,” and instilling a “professional attitude.” Hoping to create a specialized new curriculum to meet these objectives, however, is for the most part narrow-minded and misguided. “Professional standards” are readily available, and in themselves, rarely motivate (would-be) professionals to serious reflection, while “attitudinal” aspects of professionalism are probably better addressed by making medical schools places in which open, deliberate, and consistent conversation about excellence in medicine among faculty and students is a regular part of life. However, if intelligent reflection on “standards” and “attitudes” is what is desired, then before all else we need our students to be well-trained in being stimulated to reflect and in the process of intelligent reflection itself. But these are simply the aims of well-designed ethics and humanities curricula.

To act professionally, in the deepest sense, is to act responsibly in an arena defined by the traditions of a good-seeking activity (e.g., medicine, law, the military, education). To inculcate professionalism in this rich sense is necessarily to assist with the development of character and moral intelligence, but this is precisely the goal of ethics. Thus, ethics trumps professionalism. Professional behavior is, after all, only a subset of the activities, attitudes, and choices in which character is expressed—the subset defined by the specifics of the professional pursuit and the institutions in which that pursuit is conducted. If what we want is for physicians to make good professional choices throughout careers in which the circumstances of choice (social, political, economic, and technological) will no doubt continue to change, then we should want physicians who are capable of doing for themselves the thinking that leads to good choices.

**References**


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**Socialization in Medical Training: Exploring “Lifelong Curiosity” and a “Community of Support”**

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I am grateful to Delese Wear and Mark G. Kuczewski (2004) for raising concerns over the state of professionalism curricula in medical training. Despite white coat ceremonies, ethics classes, and efforts to measure performance in professionalism (e.g., communication with patients, ethics knowledge, and team building), something within the academic environment continues to circumnavigate complex dynamics. The “hidden” curriculum within this milieu has allowed cynicism to grow, abusive behaviors to be tolerated, derogatory comments to be accepted as stress relief, and self-interest to flourish. Despite attempts, unraveling the hidden curriculum remains elusive. Recognizing that the practice of professionalism continues to thwart the goals elucidated by the theory of professionalism (Ginsburg and Stern 2004; Jecker 2004), I want to explore practical behaviors that could impact medical training.

**Socialization in Medical Training: The “Dark-Side”**

I will briefly describe a model of socialization that I’ve developed to encapsulate the “dark side” of medical training. It is intentionally exaggerated and one-sided in order to exemplify issues currently understated in pedagogical literature. It attempts to illuminate detachment and unprofessional behaviors manifested after students step through the idealistic gates of medical school (Coulehan 2001).

In their first year of training, medical students join a class of 150–200 compatriots, who become their new family. Long hours of classes and the rigor of study frequently
manifest in separations, loss of prior relationships, isolation, and even depression (Christakis and Feudtner 1997). In their first year, students are also presented with a corpse for dissection. This ritual represents a “rite of passage” separating students from others who have only witnessed dead loved ones or never even seen a dead body. This passage stimulates anxiety and detachment for many students (Charlton et al. 1994; Nnodim 1996).

Third-year medical students are presented with the “short white coat,” a symbol of their subservient status on the team. This physical symbol is frequently reinforced by actions reiterating that clinical students are to “be seen and not heard.” Students recount stories in which they were never asked their name on new rotations, were not oriented to the wards, were not given lockers or told the locations of bathrooms or phones. One older medical student, who had been a confident professional before medical school, stated that he did not know how it happened, but when he donned the short white coat, he became tongue-tied and unable to express himself in this environment. Hence, third-year students can feel “stripped” of their prior identity.

Fourth-year medical students regain confidence, purposely bolstered and given authority as acting interns. Graduation day is magnificent. Students receive many pats on the back, for now they belong to the club. Unfortunately, internship deflates these feelings with long hours and grueling responsibility for the lives of extremely sick patients. Signs of depression and burnout are rampant (Shanafelt et al. 2002). One could argue that many interns show signs of post-traumatic stress disorder. Although this might seem an exaggeration, for many, internship is a difficult and frequently traumatic experience.

The previously-eager entering medical student has been now isolated from his or her roots, stripped of prior identity, enlisted in the club, and then exhausted or even traumatized. In the last two years of residency, she or he is built back up as a success story, having joined the profession of medicine. She or he has been socialized to the attitudes and nuances of acceptable professional behavior.

Socialization in Medical Training: An Alternative Model

All professionals are socialized; this is a truth of process. Unfortunately, current medical socialization seems to diminish curiosity about patients’ lives and the impact illness has upon their dignity. Medical students feel closest to patients and enjoy intimate details of their lives via extended histories. Interns and residents, faced with severe time pressures, try to herd patients through, abiding to lists and protocols for care. Fellows often replace curiosity about patients’ lives with scientific curiosity and evidence-based medicine. By the end of training, curiosity might be replaced by cynicism and altruism by a desire for personal gain.1 It is my contention that we can promote different professional outcomes by changing the environment within which training occurs.

Rhodes and colleagues (2004) offer two foundational theoretical principles (fiduciary responsibility and gaining trust) for professionalism. I propose two complimentary practical guides to recalibrate outcomes of professional socialization—maintaining lifelong curiosity2 and building a community of support. I will examine changes that might ensue if the recommendations made by Wear and Kuczewski are guided by these beacons.

First, Wear and Kuczewski recommend discourse on professional development via empowering residents and medical students to address problems in training. Residents and students are expected to have optimal insight into managing call and delineating altruism by means that also “explicate their relationship” needs. This is difficult to imagine because students are often obsessed with evaluations and residents are physically and emotionally exhausted and also seek superb evaluations for competitive fellowships. These motives, plus inexperience, might suppress trainees’ abilities to derive viable solutions.

Using lifelong curiosity as a guide to professionalism, students and residents could freely explore the management of productivity, costs, and personnel coverage; discern alternatives; offer opinions; and yet avoid responsibilities and choices beyond their administrative prowess. Their voices could be heard, but with the burden of management properly placed on faculty. Students and residents could also explore practical paths to altruism. Offering a bedpan to a patient, plumping up a pillow, or opening a patient’s food containers might be rewarded as altruistic and caring behaviors. Others might volunteer at homeless clinics or offer home visits to incapacitated patients. Student and resident efforts toward creative problem solving, as well as acts of altruism, need to be applauded by faculty, thereby enriching a community of support.

Second, Wear and Kuczewski profess that a curricular theory of professional development can be derived by students and residents via a “prise de conscience.” This reflective awareness promotes curiosity. Ideally, sensitive and compassionate physicians will ensue. Unfortunately, reflective curiosity cannot meet these goals if students and residents are also mistreated. Reflection needs to be supported by

1. After years of delayed gratification, upon completing training physicians are often focused on their income and on rebuilding their personal lives.
2. Lifelong curiosity differs from lifelong learning. Learning includes gaining any new facts, data, or experiences, whereas curiosity encompasses a specific aspect of learning manifested by a desire to explore differences, similarities, barriers, or conflicts.
action, modeled by faculty who are sensitive and compassionate with both their patients and their trainees. The teacher-learner relationship must propagate respect for each student, with awareness of power differentials and the vulnerability experienced by learners. When the teacher-learner relationship is fashioned upon mutual respect, learners become physicians with healthier patient relationships and improved patient outcomes via “parallel processes” (Shapiro 1990). By modeling admirable traits in the teacher-learner relationship, physicians bring similar traits to bear upon the doctor-patient relationship (Markakis et al. 2000), thereby promoting goals of professionalism through mutual respect and support.

Third, Wear and Kuczewski recommend changing the learning environment for professional development. Faculty efforts to improve relationships with trainees need to be mirrored by administrative efforts to reward faculty who promote curiosity and a supportive environment. Professionalism means fostering a collaborative environment of respect—from the top down. Basic ethical principles of respect for persons and inherent dignity are frequently defiled on the wards. These behaviors must become completely unacceptable. Medical students should not be denigrated—nor should nurses, ward staff, other specialists or healthcare professionals, or, least of all, patients. Nonetheless, denigrating humor is endemic to hospitals and is self-perpetuating. Negative values demonstrated on the wards are frequently avoided rather than actively countermanded (Burack et al. 1999). Faculty must begin to speak up against derogatory statements made on the wards. Trainees also need to be assured of systematic avenues to report untoward faculty behaviors. Real consequences should ensue for trainees and faculty who persist in inappropriate behaviors. Systematically reinforcing respect promotes a community of support that allows curiosity to thrive.

Lastly, Wear and Kuczewski state medicine has a duty to advocate for the well being of society by educating trainees about social injustices. Learning theories of inequality and roots of economic disparity might not be enough. Each trainee can use curiosity to examine personal prejudices. By broadening “diversity” and “oppression” beyond persons of color, religion, gender, and socioeconomic status—to include criminals; persons with AIDS, physical or mental disabilities, or morbid obesity; gays and lesbians; and even prostitutes or beauty queens—students might begin to recognize personal biases. Once a bias is admitted, curiosity can take over. A student could spend one night a month, or an intensive one-week period, with a person matching the student’s unique bias. The student could observe differences and similarities to her or his own life, thereby allowing empathy to grow. By supporting trainees in nonjudgmental reflection, they can openly explore the lives of “others.” I believe this could create realistic and lasting empathy for issues of justice and injustice within medical care.

It is time for the academic medical community to seriously evaluate unfavorable consequences to professionalism resulting from socialization. If the environment within which students and residents train does not change at a fundamental level, attempts to fix curricula in professionalism will most likely remain inadequate. By modeling and reinforcing lifelong curiosity and by providing a community of support to trainees, physicians can embrace healthy personal habits and focus upon improving patient well-being through empathic, responsive, and coordinated healthcare systems.

References
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