Introduction

Richard L. Cruess, Sylvia R. Cruess, and Yvonne Steinert

When the first edition of *Teaching Medical Professionalism*[1] was published, considerable experience on teaching and assessing professionalism had been developed in medicine's educational establishments. The book was therefore based upon a body of knowledge that existed, and the authors formed their recommendations upon their own experiences and that of others working in the field. The emphasis has recently shifted from teaching professionalism to supporting professional identity formation,[2–4] despite a lack of literature outlining how professional identity formation can be supported throughout the continuum of medical education. It is our hope that this book can partially fill the void, as it brings together educators and researchers who have focused on the subject of professional identity formation in medicine.

The idea that physicians actually have a professional identity is not new. In 1957, Merton published one of the first studies of the sociology of medical education.[5] In the introduction to the book, Merton stated (p. 5) that medical education has a dual purpose: "to shape the novice into the 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."[5] Through the ages, great emphasis has been placed on ensuring that medical graduates possess the requisite knowledge and skills, using increasingly sophisticated methods of teaching and assessment.[6]

Until recently, it was assumed that medical students and residents would acquire their professional identities by patterning their behavior after respected role models.[7] The desired identities were encompassed in the concept of professionalism, and physicians were expected to behave like professionals. While there were frequent references in the literature to professionalism, it was not addressed explicitly, being mainly taught in the informal curriculum.

There is agreement that this historic system functioned reasonably well, as long as a homogeneous medical profession that was largely male and made up of members of the dominant social group served a comparably homogeneous population.[7] There was also general agreement between medicine and society on shared values. The world changed after World War II. As the medical profession and the society that it served became wonderfully diverse, passing on the traditional values cherished by both the profession and society became more difficult. This was occurring as medicine and systems of healthcare delivery became more complex. The day of the solo practitioner treating a paying patient is a part of history, along with a type of professionalism that has been termed "nostalgic."[8] As the practice of medicine was transformed after World War II from a cottage industry into an activity that consumes a significant percentage of the gross national product of every country, medicine's adherence to its traditional value systems was questioned.[9,10] Individual physicians and the profession were thought to place their own interests ahead of the interests of patients and of society, and the profession was accused of a lack of rigor in setting and maintaining standards. There was a loss of public trust in individual physicians and in the profession. There was general agreement in both society and within the medical profession that medicine's professionalism was threatened.[6]

The medical profession did react, motivated in part by a desire to maintain medicine's privileged position in society.[11] Nevertheless, the response did include attempts at more rigorous and open self-regulation and a major effort on the part of the educational establishment to ensure that each physician entering practice would understand the nature of professionalism and the importance of meeting medicine's professional obligations.[7,12] What has been termed "the professionalism project"[13] began in the

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1980s and 1990s. The objective was to teach professionalism explicitly, thus transferring it from the informal to the formal curriculum. As the movement grew, definitions of professionalism emerged,[14] and methods of teaching[15] and assessing[16] professionalism were developed. Faculty development programs also supported these activities.[17] Finally, the importance of professionalism in the medical curriculum at both the undergraduate and postgraduate levels was established when accrediting bodies throughout the world required that it be taught and assessed.

Until now, the educational objective has been teaching professionalism, with the implication that it is incumbent upon students to learn it, along with other aspects of the formal curriculum. The literature on teaching professionalism does contain frequent references to the desirability of medical students and residents acquiring a professional identity. However, as was true of the words *profession* and *professionalism* prior to the 1980s, the concept remained aspirational in nature and was rarely defined. This situation has changed dramatically during the past decade. An extensive literature exists in developmental psychology and other academic fields that describes how each human being proceeds through developmental stages from birth and throughout adult life, emerging with a unique identity or identities.[18] Individuals with backgrounds in both medicine and the social sciences have examined the nature of professional identity in medicine, provided definitions of it and of identity formation, and have explored the nature of the process of socialization through which professional identities are formed.[4] There is now an extensive literature, easily accessible to medical educators on the subject.

As this literature appeared, there began to be questions on the assumptions underlying programs devoted to teaching professionalism. It was assumed that if practitioners understand the nature of contemporary professionalism and the obligations that they must fulfill in order to meet societal expectations, they would consistently exhibit professional behaviors. Hafferty[19] wondered if this is sufficient. He asked, "Does it really matter what one believes as long as one acts professionally?" (p. 54) He answered his own question[19] by stating that "the fundamental uncertainties that underscore clinical decision making and the ambiguities that permeate medical practice, require a professional presence that is best grounded in what one is rather than what one does." (p. 54) The Carnegie Foundation report on the future of medical education broke new ground when it recommended that professional identity formation in medicine represent a foundational element to medical education.[2] Subsequent to this influential report, others have supported this approach, agreeing with Merton et al. that professional identity formation is a fundamental aspect of medical education.[2,4]

When assisting learners at all levels of medical education to develop their own professional identities becomes the educational objective, the emphasis shifts from faculty members teaching professionalism to a new paradigm in which students are actively engaged in the development of their own professional identities. The role of faculty is to assist students in understanding the process of identity formation and of socialization, and to engage them in monitoring their own journey from layperson to professional.

We believe that the true aim of medical education throughout the ages has always been the creation of a professional identity in emerging physicians. If this transformational change is accepted, a new approach to education based upon the duality proposed by Merton[5] is required in which knowledge, skills, and professional identity are given equal attention.

Concurrent with an interest in identity formation has been the growing acceptance of the concept of communities of practice as being applicable to both medicine and medical education.[20] Medical students voluntarily wish to join the community of practice that is medicine, and, in the process of joining, they acquire the identity of members of the group. In acquiring this identity, they must also accept the norms of the community of practice.

If the objective of medical education becomes supporting professional identity formation, there are major implications for curricular design. New educational objectives must be established; definitions of professionalism, professional identity, and socialization currently available must be incorporated into the curriculum; and methods of engaging and supporting students and residents as they develop their identities must be developed. Faculty development is essential, and methods of assessing progress toward a professional identity must be created.

Much has already been accomplished. The experience gained in teaching professionalism is invaluable and can serve as the basis for instituting programs to support professional identity formation. The norms of the community of practice, of great importance to the professional identity of physicians,[4,20] are

encompassed in the word *professionalism*. Programs that have been devoted to teaching professionalism can use these norms as they move toward supporting professional identity formation.

The aim of this book is to assist those who wish to institute programs devoted to professional identity formation. The content of many chapters is truly new and innovative and built on past achievements. The authors have examined the foundational aspects of medical education through the lens of identity formation. In many instances, this reorients what has been done in the past without requiring great changes. In others, it provides new insights that can guide us in the future. As an example, examining remediation or continuing professional development through the lens of identity formation can engender hope for real progress in areas that have proved difficult in the past.

The book provides guidance on what must be taught, the cognitive base of professionalism, the theoretical basis of identity, and the nature of the process of socialization. It describes the educational theory and strategies for supporting professional identity formation. It also analyzes those educational methods most relevant to identity formation, role modeling and mentoring, and experiential learning and reflection. General principles for establishing programs on professional identity formation are provided, along with information relevant to including professionalism in identity formation. Assessment and remediation are reinterpreted in terms of identity formation, methods of reorienting faculty development are outlined, and the important role of licensing and certifying bodies is discussed. A section of the book contains case studies from institutions that have begun the transformation from teaching professionalism to supporting professional identity formation at the undergraduate and postgraduate levels. A case study on changing the learning environment so that it is supportive of identity formation is also present. In the final section of the book, the evolving nature of professional identities is recognized in an attempt to look forward to the possible identities of the future.

It is hoped that this book will be of assistance to those responsible for designing and implementing programs of instruction on professionalism and professional identity formation. It should also be of interest to both teachers and learners. While aimed specifically at the medical community, it should be noted that the terms *profession, professional*, and *professionalism* are generic and applicable to other occupations, both within and outside the healthcare field. All healthcare professionals have professional identities that are formed through socialization. The authors hope that the chapters in this book will be of assistance to those responsible for educating other members of the healthcare team, with whom future physicians will most certainly interact. Those who read the book from cover to cover can obtain a comprehensive background for program development and teaching in the field of medical professionalism. However, each chapter can stand alone and be used by readers with specific areas of interest.

The authors who have contributed to this work are true experts in the field and have been pioneers in addressing professional identity formation. The editors would like to thank each and every one for their support, their extraordinary creativity and innovation, and their commitment to the project. We are also grateful to the students, residents, and faculty members of McGill University for their enthusiastic participation in our work. Finally, we thank our colleagues at the Centre for Medical Education for their intellectual engagement, honest feedback, and creative suggestions as we have tested our concepts and beliefs with them. We are also grateful to Melissa Como for her assistance in preparing this volume.

William Sullivan[21] has written that "recognizing the formative nature of medical education gives medical educators an opportunity to become more self-aware and intentional about how future physicians actually develop." (p. xi) It is our hope that by intentionally and explicitly addressing professional identity formation during the continuum of medical education, we will move toward our aspirational goal of ensuring that each graduating medical student or resident "thinks, feels, and acts like a physician."

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Part I

What is to be taught and learned

Chapter 1

Professionalism and professional identity formation: the cognitive base

Richard L. Cruess and Sylvia R. Cruess

The task of medical education is to "shape the novice into the 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*."[1] (p. 5)

During the past few decades, it has become apparent that the issue of the professionalism of individual physicians and of the medical profession must be addressed explicitly at all levels of medical education. For this reason, the subjects of professionalism and professional identity are being addressed directly throughout the continuum of medical education.[2–10] As is true of any significant topic that must be learned, there is a defined body of knowledge called the cognitive base that serves as the basis of the teaching, learning, and assessment of the subject. The purpose of this chapter is to outline the cognitive base that should underpin educational activities designed to support learners in medicine as they become professionals and acquire their professional identities.

As physicians, patients, and members of the general public have come to believe that medicine's professionalism is under threat, virtually all have concluded that any action to address the issue must include major initiatives throughout medical education aimed at ensuring that physicians both understand the nature of contemporary medical professionalism and live according to its precepts – that they come to "think, act, and feel like a physician."[1–6] As a result, there is now a substantial literature describing how this can best be accomplished, with a recent shift in emphasis toward supporting professional identity formation.[7–10]

For centuries, professionalism as a subject was not addressed directly. There were no courses on professionalism and it was not included in the standard medical curriculum. This is not because it was deemed unimportant. The Hippocratic Oath, subsequent codes of ethics, and a host of writers addressed the values and beliefs of the medical profession, often linking them to the word "professionalism." However, it was assumed that these values and beliefs that are the foundation of the profession would be automatically acquired during the educational process as students "acquire the complex ensemble of analytic thinking, skillful practice, and wise judgment."[5] The learning of professionalism depended heavily upon the use of role models, that is, situations in which students, residents, and, indeed, practicing physicians patterned their behavior on "individuals admired for their ways of being and acting as professionals."[11] While this method remains essential and powerful, by itself it is no longer deemed adequate.[3,4,6,12]

At first, general agreement developed among educators that professionalism must be taught and evaluated as a specific topic at both the undergraduate and postgraduate levels. In recent years, certifying and accrediting bodies have required this.[13–16] As a result, a substantial literature emerged defining medical professionalism and its relation to medicine's social contract. The difficult issue of how best to assess professionalism was also addressed.[17,18] While disagreements continued to exist over the nature of professionalism and how best to communicate it, there was agreement that what had been largely implicit in medical education must be made explicit.[18] The intent of the first edition of this book was to present the theoretical basis for teaching and assessing professionalism and to outline the means by which this could be accomplished, based on the knowledge and best practices of the time.

The commonly stated educational objective was to ensure that learners at all levels understood the

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cognitive base of professionalism, internalized the value system of the medical profession, and consistently demonstrated the behaviors expected of a professional.[19] While the idea of professional identity was occasionally invoked, assisting students to develop a professional identity was not a stated goal, in part due to a lack of understanding of the process of identity formation within the medical profession. This is no longer true. There is now an extensive and rich literature devoted to professional identity formation in medicine that has contributed to our understanding of the nature of medical professional identity and the process of socialization through which this identity is formed.[20–47] Accompanying the emergence of this literature has been the belief by many that the real objective of teaching professionalism has always been to assist students as they develop their own professional identities. Teaching and assessing professionalism have thus represented a means to an end rather than ends in themselves. As a result, there have been calls to reframe medical education around professional identity formation,[7,9,10] an approach that we strongly support.

This does not mean that past efforts devoted to the teaching and assessment of professionalism are without value and can be discarded. The attributes of the professional represent the norms to which learners aspire. The programs devoted to the teaching and assessment of professionalism can be modified to support the educational objective of assisting learners as they develop their own professional identity or identities, particularly as both lean so heavily on reflection as a formative element.

This chapter will propose that medicine represents a community of practice (or practices) that students and residents wish to join. As they join the community, they acquire the professional identity expected of members of the community. They must learn and adhere to the values and norms of the community to acquire this identity. Understanding the values and norms requires a definition of profession or professionalism, the reasons for the existence of professions, knowledge of the attributes of a member of the profession, and the relationship of professionalism to medicine's social contract with society. This material, along with an understanding of the concepts of professional identity formation and socialization, constitute the cognitive base to be communicated to those wishing to enter the profession of medicine.

Medicine as a community of practice

Social learning theory has been invoked to both understand and guide medical education (see Chapter 5). The concepts of communities of practice and situated learning developed by Lave and Wenger[48] have been particularly helpful because they appear to reflect the reality of both medical education and practice. The concept is presented schematically in Figure 1.1.

Lave and Wenger[48] and Wenger[49] propose that social interaction between individuals promotes learning, and that a community of practice is created when those who wish to share a common body of knowledge engage in activities whose aim is to become knowledgeable and skilled in a defined field.

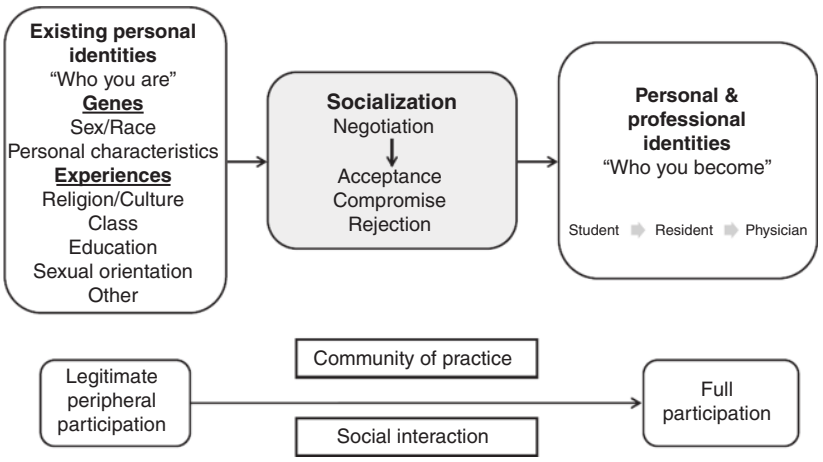

Figure 1.1. A schematic representation of professional identity formation and socialization, indicating that individuals enter the process of socialization with partially developed identities and emerge with both personal and professional identities (upper portion). The process of socialization in medicine results in an individual moving from legitimate peripheral participation in a community of practice to full participation, primarily through social interaction (lower portion).[46] Reprinted with permission by *Academic Medicine* © 2015.

The result is the acquisition of both a body of knowledge and skills and a set of acceptable behaviors – a way of "being." The learning, which is both explicit and tacit, takes place within the defined domain and thus is "situated." As a consequence, the individual moves from "legitimate peripheral participation" to full participation in the community. An important aspect of full participation, according to these authors, is the acquisition of the identity associated with the community. This activity is voluntary – the individual wishes to join the community and over time accepts its values and norms. The movement from peripheral participation to the center is not linear, but occurs in stages, proceeding from observation to imitation to carrying out uncomplicated tasks and culminating in more complex activities. This description applies to the transformation of a medical student from a member of the lay public to a professional. The sense of belonging that accompanies the development of a professional identity is an important component of a community of practice. It translates into the collegiality of the profession.[50] Finally, the profession exerts a compelling social influence on its members, as compliance with professional norms and values eventually emerges from within the individual.[51,52]

The health of the community depends upon the voluntary engagement of its members and on the presence of leadership. According to Wenger et al.[53] (p. 11), "one of the primary tasks of a community of practice is to establish the common baseline and standardize what is well-understood." These standards represent the norms of medicine's community of practice. While there certainly are values that have persisted through the ages, such as caring and compassion, some norms change over time as the social contract between medicine and society evolves, altering the expectations of patients, society, and physicians.[54] Each individual wishing to join the community must adhere to the majority of these norms. Failure to do so can inhibit progress to full membership or elicit sanctions or exclusion from the community.[24,51]

In the past, the identity of physicians has been exclusionary because the profession was dominated by white males of the dominant religion.[22,24,26,31] The hierarchical organization of the profession tended to perpetuate the existing power relationships, making change difficult. Even though progress has been made, with the community becoming more representative of the society it serves, minority and class distinctions still exist, making entry challenging for many.[22,24,31,37] In addition, and without question, tension arises between the imperative to impose norms and standards in an effort to homogenize values and the desire of individuals to maintain important aspects of their own identity as they join the community of practice.[26,37]

The description of communities of practice presented by Wenger et al.[51] (p. 38) seems to describe the practice of medicine: "a set of socially defined ways of doing things in a specific domain: a set of common approaches and shared standards that create the basis for action, communication, problem solving, performance, and accountability." This is an accurate description of the practice of medicine.

Profession, professionalism, professional identity, and professional identity formation

In dealing with the interconnected concepts of profession, professionalism, professional identity, and professional identity formation, words and definitions become important. This is particularly relevant because the literature frequently states that professionalism is difficult to define, often accompanied by the admonition that it cannot be taught, learned, or assessed without such a definition.[18,55] We have long believed that the definitions, most of which deal with the word "professionalism," enjoy many more commonalities than differences. What is unquestionably true, and widely accepted, is that each institution involved in teaching professionalism or promoting the development of professional identities must have a set of institutional definitions accepted by all within the institution.[2,3,18] What is taught, learned, and assessed should spring from these definitions. What cannot be explicitly defined cannot be taught, learned, or assessed.[18]

If medical education is to be reframed around the concept of professional identity formation, the definitions of identity, professional identity, and professional identity formation become foundational elements of any educational program. The definitions of the words "profession" and "professionalism" become important descriptors of the desired identity associated with medicine as a community of practice. They should both represent the historical value

systems of medicine as a healing art and reflect their contemporary state.

Chapters 3 and 4 present in-depth analyses of the nature of professional identity, professional identity formation, and socialization. In this chapter, we will use material drawn from these chapters so that it can serve as the basis of educational programs to support professional identity formation.

Professional identity

The Oxford English Dictionary definition of identity is the following: "a set of characteristics or a description that distinguishes a person or thing from others."[56] While this definition is certainly accurate, it is too broad to be useful as the basis of a program in medical education. With our colleagues in the Faculty of Medicine at McGill University, we have therefore developed a definition of medical professional identity. A physician's 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."[9]

Conceptually, professional identity formation must be congruent with the processes through which all human beings develop a personal identity.[51] Psychological theory proposes that individuals proceed through life continuously organizing their experiences into a meaningful whole that incorporates their personal, private, public, and professional "selves."[51,52,57–61] As they pass through each stage, from infancy to childhood, adolescence, and beyond, individuals gain experience and become capable of constructing an increasingly complex persona.

Medical students enter medical school with clearly established identities that have been formed since birth (see Chapter 3). Developmental psychologists have contributed a rich literature that documents the various developmental stages through which humankind pass. Piaget and Inhelder,[57] Kohlberg,[58] Erikson,[59] Kegan,[60] Marcia,[61] and others have contributed to our understanding of the process. Kegan's framework[60] has proved particularly helpful and it has been applied to professional identity formation in medicine, dentistry, and the military. Two points are of particular significance to medical educators. First, the identities of individuals beginning their medical studies, while containing elements and characteristics that will remain with them throughout their lives, are still not fully formed and can and will be influenced by multiple factors, including the educational process.[57–61] Second, the process of choosing an occupation has a significant impact on identity formation. Becoming competent in a chosen field has a stabilizing influence on one's identity.[59] Thus, learners at both the undergraduate and the postgraduate levels of medical education are in a transformative phase of their development. Educational programs can either support students through this journey or divert them from it.

Figure 1.1 presents a schematic representation of the process.[46] Students enter with identities that have resulted from the impact of both internal and external factors.[51,60,61] Individuals possess personal characteristics that are genetically determined – physical characteristics, gender, race, and a host of others. However, the sum total of their experiences in life has an enormous and lasting impact – religion, culture, socioeconomic class, level of education, sexual orientation, and many others.

During their educational experiences, learners in medicine become exposed to the norms of the community of practice and, if they wish to acquire the identity of a physician, they must adapt to these norms.[25,38] This involves a series of negotiations, most of which are internal to the self. An individual can accept all or some of the norms or can attempt to compromise by making accommodations to any given norm or practice. Finally, he or she can reject some norms. The recent emphasis on lifestyle represents an instance of a generation rejecting patterns of practice that were widely accepted in the past.[62,63] When significant numbers of learners wish to compromise or reject some of the accepted norms of the community, the negotiations are no longer internal – they take place within the larger community. It is important that this be understood, because the environment within which the majority of these negotiations take place is the educational community.

Learners emerge from the process of socialization with an altered identity that contains the core of who they were when they entered medical school and who they have become.[1,26,64,65] Transitions are important.[39,43,64,65] Entering medical school represents a transition, as does beginning residency and practice. Medical students have been shown to have a distinct identity that is different from that of a resident, and practitioners have their own distinct identities.[64,65]

Without question, there is tension in all phases of development that arises as individuals attempt to retain elements of who they are, as they are consciously and unconsciously being altered into who they are to become.[28,29,59]

It is important to emphasize that when the educational goal becomes the formation of a professional identity, the nature of that identity must be clearly delineated. Daniels[66] and others[67,68] have suggested that there is a socially negotiated ideal of the "good physician," and that, at any given point in time, a physician's behavior is both guided and constrained by this ideal. While there is some latitude in the expectations of both physicians and society due to individual, national, and cultural differences and specialty choices, certain core values such as caring, compassion, commitment, confidentiality, honesty, and integrity are universally accepted.[2,4] In joining the profession, an individual must accept these values and has a limited ability to pick and choose among the obligations resulting from them. The concept is not immutable and is being constantly renegotiated as "conditions inside and outside medicine change."[54,66] What it means to be a professional establishes the norms of the identity of an individual who wishes to join medicine's community of practice. Thus, the definitions of profession and professionalism, as well as the attributes of the professional, can provide a guide to assist learners who are attempting to "integrate their various statuses and roles, as well as their diverse experiences, into a coherent image of self."[8]

Professional identity formation

Jarvis-Selinger et al.[8] have described the process of professional identity formation as "an adaptive developmental process that happens simultaneously at two levels: (1) at the level of the individual, which involves the psychological development of the person and (2) at the collective level, which involves the socialization of the person into appropriate roles and forms of participation in the community's work." (p.1185) Thus, the journey from layperson to professional is internal to the self but is influenced by many external factors, both within the community of practice and external to it.

Profession and professionalism – defining the norms

As we have come to believe that medicine is a community of practice, the word "profession" has come to represent and define this community. A member of the community can be described as a professional, and professionalism will outline the behaviors expected of a professional. The attributes ascribed to a professional become descriptive of the professional identity to which individuals aspire. Thus, the efforts of the past few years, whose aim was to make the teaching of professionalism more explicit, can bear fruit when professional identity formation becomes an educational objective. The norms of the community of practice are contained in these definitions and descriptions and can be readily adapted to support professional identity formation.[9]

Although there is general agreement on the salient features of professionalism,[4,69] it has proved difficult to develop universally accepted definitions of "profession" and the words "professional" and "professionalism," which are derived from it. In part, this stems from the frequent use of the words as if they are interchangeable, which they are not. However, another cause is the difference in the background and approach of those studying all professions, including medicine.[69–71] The largest independent body of literature referring to the professions is found in the social sciences. Sociologists have been studying and writing about the professions for more than a century, and medicine has figured prominently in this literature. While there are certainly different approaches within the field of sociology, the primary interest is in the organization of society (and of work within society) and the role of the professions in this organization.[70] While sociologists recognize the importance of the doctor–patient relationship, they are primarily interested in the interface between the medical profession and the society which it serves.

To members of the medical profession, the definition must convey something more than the organization of society, important as this may be. Physicians require something that can assist in defining their own professional identity and establishing the ideology of the profession,[5,8,30,71] thus helping to establish the ideals to which they aspire and the norms to which they must adhere. Those responsible for teaching professionalism must address aspects relating to the relationship of physicians with both patients and society, as there are clearly expressed concerns about the performance of individual practitioners and of the profession in both areas.[5,72,73] These concerns relate to issues of morality, conflicts of interest, the state of the doctor–patient relationship, self-regulation, and

to the impact of the healthcare system on the practice of medicine.[2–5,72,74] For this reason, we believe that any definition of medical professionalism must encompass the approaches found in both the medical and the sociological literature.

The literature contains many definitions of profession, professionalism, and medical professionalism. Most are similar and present common concepts because they generally begin with the assumption that the physician is a virtuous person and that the practice of medicine is a moral endeavor.[4,69–71] Profession, derived from the word "profess," is the etymological root of the frequently used terms professional and professionalism.[56]

It seems to us preferable to start with a definition of the root word "profession." We will provide two definitions, either of which can easily serve to communicate the norms of medicine's community of practice and hence of the desired professional identity.

Those preferring a short definition that stresses broad categories generally include descriptions of professions as containing common elements, work based on command of a complex body of knowledge, autonomy (sometimes linked to self-regulation), and a service orientation. We would suggest the following, developed by Starr in his seminal book, *The Social Transformation of American Medicine*[74] (p. 15):

> Profession: "An occupation that regulates itself through systematic, required training and collegial discipline; that has a base in technical specialized knowledge; and that has a service rather than profit orientation, enshrined in its code of ethics."[74]

It must be stressed that if this definition is to be used as a part of the cognitive base, the attributes of the profession that are outlined below must also be taught and should be linked to one of the broad themes included in the definition.

For those who prefer a more complete definition, the following is offered. It is based on the Oxford English Dictionary's,[56] to which have been added elements drawn from the medical and social sciences literature, which are felt to be fundamental parts of contemporary professionalism. Its disadvantage is its length and complexity, but it does contain the major elements that the literature indicates should be included. In addition, it indicates that professional status is granted by society, with the important implication that society can alter the terms should it wish to do so.

> 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, to the profession, and to society."[75]

It should be pointed out that there are other examples of long and short definitions of "profession," "professionalism," and "medical professionalism" that are both acceptable and operationally useful.[69] The *International Charter on Medical Professionalism* explicitly outlines the nature of professionalism, stressing the obligations of a medical professional in contemporary society,[76] as does Swick's *Towards a Normative Definition of Medical Professionalism*.[77] Both are comprehensive and can serve effectively as the basis of a program on professionalism and professional identity formation.

Professionalism

Professionalism is a term used to describe the behavior of a professional. The Royal College of Physicians of London definition, "a set of values, behaviors and relationships that underpins the trust the public has in doctors,"[78] is commonly used. When the emphasis was on teaching and learning professionalism, it was particularly useful, because the assessment of professionalism leaned heavily on the assessment of observable behaviors – "what one does."[17] If professional identity formation becomes the educational objective, "what one is" becomes much more significant in terms of both pedagogical approaches and assessment methods.[9,10] Behaviors will continue to have an important place in the educational continuum as they assist in assessing progress toward the acquisition of a professional identity. In addition, unprofessional behavior will always be with us, and it will therefore be necessary to continue to assess behaviors.