Viewpoint: **Teaching Professionalism: Is Medical Morality a Competency?**

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Abstract

The Accreditation Council for Graduate Medical Education (ACGME) has declared medical professionalism to be a competence analogous to competence at medical practice. Medical educators accordingly seek to develop ways in which to teach and assess medical professionalism as they now teach and assess clinical medicine. The author contends that professionalism is medical morality and that while being moral in the world of medical practice can involve skill, morality differs from domain-based skills such as medicine in important respects. The norms of morality are both more exigent and more difficult to live up to than the norms of medical expertise. And any morality we learn in the course of medical education does not simply establish itself in our repertoire as a new skill, but must contend with our preexisting moral outlook.

These differences have implications for the inculcation and assessment of professionalism. Professionalism can be taught, but the current model employed by medical education, cognitive engagement followed by supervised practice, will not suffice for its inculcation. Nor will objective cognitive or behavioral testing suffice for its assessment. Medical educators can seek and achieve compliance with professional norms during the formative periods of training (internship and residency). Committed observance of professional norms cannot be coerced but may emerge among trainees through their responsiveness to the lived moral life of virtuous faculty, encouraged by the tacit and explicit invitation of such faculty to imitation over time. To be valid, assessment of professionalism must be subjective, narrative, personal, undertaken during periods of stress, and obtained during routine activity (rather than on special occasions).

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For the past 15 years, physicians in the United States have increasingly worried about an erosion of ethical standards in their caring for patients, which they have sought to stem through reinforcing physician "professionalism." Traditionally a concern of sociologists studying the autonomy and power of the medical profession in society, "professionalism" has come to designate the ethical obligations toward patients and society that are entailed in the physician's role, which many believe are threatened by the intrusion of third parties such as managed care organizations into the doctor–patient relationship. Calls for professionalism have been especially pressing among medical educators. How to develop and evaluate professionalism in physicians-in-training has become an important issue for medical schools and residency training programs. Medical educators and patients alike want physicians who are "professional" in this sense: just, altruistic, conscientious, compassionate, honest, and scrupulous about financial conflicts of interest.

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Professionalism: A Call for Morality as Expertise

But just what are we wishing for in wanting these qualities in our physicians? Are we asking for mastery of a particular domain of knowledge and skill, which can be taught in a manner analogous to the teaching of clinical medicine? Or, insofar as we want physicians to be "good people" who will do the right thing in situations demanding right action, is something more required? The Accreditation Council for Graduate Medical Education (ACGME) now defines professionalism as one of several competencies that medical trainees are expected to acquire during their training.[1] David Leach, discussing professionalism on behalf of the ACGME, considers it to be a species of knowledge or skill that physicians-in-training must acquire as they do that of medical practice, or, for that matter, bicycle riding or chess playing.[2] He draws explicitly upon a model of skill acquisition developed by the philosopher Hubert Dreyfus,[3] which he proposes as the appropriate means for medical trainees to develop professionalism.

Dreyfus's model offers a sophisticated account of developing expertise, of the ways in which neophytes become experts at bringing both the "knowing why" and the "knowing how" of particular practical skills to bear in concrete situations. Dreyfus himself believes that morality is a form of expertise that his model can illuminate,[4] and Leach echoes this view. Other medical educators also view the inculcation of professionalism as broadly analogous to the teaching of medicine in medical schools. That is, they suggest that certain academic disciplines offer a "knowledge base" for professionalism, which can then be taught in its applications during the clinical years of medical school, if the school offers the right kind of mentoring and "hidden curriculum," the moral lessons taught by residents and faculty in university hospitals in the clinical milieu outside of the formal curriculum.[5]

Inculcating medical ethics is often held to play an important part in the teaching of professionalism. As with the rest of the clinical curriculum, ethics is generally taught as offering students a skill, primarily cognitive in this instance: a set of conceptual tools with which to clarify

and respond to moral difficulties that arise in the practice of medicine. The focus of medical ethics is generally on "hard cases" that arise in end-of-life care, or organ transplantation, or reproductive medicine, or certain kinds of medical research, in which it may be difficult to discern the right thing to do. Medical ethicists seek to enable medical trainees to deliberate use of the conceptual apparatus of ethics to decide upon morally acceptable courses of action in difficult situations.

This approach to morality as a form of expertise posits the human agent in moral situations as deploying a cognitive and perceptual apparatus to attain the proper moral perspective; we learn to "see" the moral aspects of situations properly through guided instruction, and then to "apply" moral principles aptly in clinical situations. Morality then becomes a kind of skill: just as one makes use of medical expertise to reach the proper medical diagnosis, chess-playing expertise to play a good chess game, or botanical expertise to identify a plant, one uses moral expertise to properly see the moral aspects of situations. The proper "seeing" seems to be the essential point; little attention is given to acting rightly once one has seen, or to any possible difficulties in keeping to high moral standards in one's continuing moral life.

As attractive as it may be to view professionalism as expertise or as a competence, I will contend that in asking for professionalism, that is, for just, altruistic, conscientious, and compassionate physicians and trainees, medical educators are asking for morality, which is at bottom asking for more than expertise. The bread and butter of morality in medicine is not in the "hard cases," where the right way forward is difficult to see; it is in acting rightly when the right path is clear before us but other pressing needs and desires pull us away from that path in the midst of day-to-day medical routine, under the often burdensome stresses of contemporary medical practice. Doctors in training likely suffer such temptations even more than doctors in practice; the work they are doing, such as specialized inpatient care in university hospitals, is often at the highest level of intensity in contemporary medicine; such work is new to them, and the more stressful on that account, in spite of their close supervision. They must answer their supervisors as well as to patients; and their status as trainees puts them in a kind of uneasy equilibrium with other hospital staff, their actions being often subject to question. And, at least until recently, they contended with long hours of work that kept them exhausted and away from their families.

Professionalism in training means taking the time and making the effort to do the right thing when the path of least resistance would be to take an easier way out, allowing the demands of, say, the next half hour, or one's hunger or anxiety or fatigue or desire to leave the hospital, to override moral considerations. In asking for professionalism medical educators are asking for compassion, kindness, honesty, and intellectual rigor all to be exercised when the chips are down—not simply for a kind of cognitive and perceptual capacity that, once developed, will inevitably be the lens through which a physician correctly views moral issues and that, of itself, will be sufficient to direct and enable moral action. In what follows, I will try to elucidate both the aptness and the limits of an analogy between professionalism and expertise. I will suggest that differences between morality and other kinds of expertise preclude successfully teaching morality in the same way that we teach clinical medicine. This is not to say that professionalism cannot be inculcated during medical training. But I suggest that the task may be harder than we think and may require of medical educators a degree of personal virtue and involvement with trainees that most of us perhaps do not really contemplate, let alone achieve. I also wish to point out that success cannot be guaranteed, even when we do achieve such virtue and involvement.

Morality and Expertise

The analogy between morality and skill or expertise is in many respects an apt one. While morality encompasses all of social life, it can be usefully analyzed as a delimited domain, similar enough in that respect to learning medicine or driving a car or playing chess. And the neophyte's task, in morality as in other domains amenable to skill, is to learn her way around the moral domain, recognize its features, learn the appropriate language for describing them, and describe them correctly. According to Dreyfus's model, skillful apprehension begins by making extensive use of reasoning but ends up relying more upon perception. The acquisition of medical skill fits this model well. In diagnosing a case of chest pain, the neophyte medical student will laboriously cycle through the differential diagnosis, comparing each possible cause of chest pain with the patient's symptoms and findings. The expert may almost immediately see the case in the proper light, and simply use a few questions and diagnostic studies to confirm her impression of the diagnosis.

The acquisition of morality also fits Dreyfus's model well. As neophytes in learning morality, we begin by using the maxims and principles offered to us by our mentors in identifying and characterizing the relevant moral aspects of situations. As we progress, we spend less and less time consciously applying maxims to pick out relevant moral particulars and figure out how to respond to them; we come simply to perceive the morally relevant aspects of situations and so to adopt a moral perspective on them without deliberation (unless the situation is unusually confusing or unclear). Our acquisition of expertise is marked by a transition from detachment to involvement; moral perception is emotionally charged, and part of taking on a moral stance is not only to see situations in a framework of moral concepts, but to feel the appropriate moral emotions corresponding to moral categories. And, as in practicing medicine, mastery can be achieved only by participation in assessing and responding to moral situations under the guidance of mentors. Most of us learn morality in this way under the guidance of our parents.

But developing morality is also very different from mastering skills at morally neutral tasks. To begin with, it is not a skill that we learn de novo. As we look back at our experiences, they are always colored by moral perceptions and perspectives. Very young children distinguish moral from conventional demands without having been taught to do so.[6] While our sense of morality develops during childhood and adolescence, that development involves not the implantation and cultivation of something foreign, but rather the pruning and shaping of an indigenous growth, there before we were instructed

about it. We may be amenable to having our moral vision sharpened, or even redirected, but we do not need to acquire it as a new skill or faculty as medical trainees acquire the skill of medical practice.

Thus, at the outset of professional education, none of us are moral novices in the same sense as are medical students with their first patients. We take moral stances on situations and people perceptively, in the "expert" mode. Hard cases may lead to deliberation, but most of our moral life consists of demands or responses that we see and make without having to reason. The moral emotions of shame, guilt, and approval accompany our perceptions of moral demands and motivate our moral responses. We need not take a side in the ongoing dispute in both philosophy and psychology as to whether reason[7–9] or emotion[10,11] "wears the trousers" in determining our moral responses; it is enough to note that ongoing moral life (as opposed to the first steps in morality of a young child or the consideration of hard cases by a morally developed adult) is heavily dependent on emotional responses that are largely automatic.[12,13] We do not consciously put on our moral spectacles when a situation with moral aspects confronts us; an aptitude to see moral features is built into our perception and we see right or wrong in the situation according to our particular moral vision, finding ourselves subject to moral emotion accordingly.

The peculiar character of the emotions accompanying our moral responses suggests that morality is special, different from other modes of engagement with the world, including forms of expertise such as those of the scientist that target aspects of the world fitting into an intersubjectively verifiable "realm of law." The emotions of shame and guilt make moral failure a different kind of experience than the kind of disappointment that accompanies a botched recipe or a missed diagnosis or a blocked shot—presuming the absence of a moral component in our failure to achieve those exercises of skill. John McDowell points to this special quality in noting that moral norms do not merely compete with other norms or demands; they silence competing imperatives to action. We fail not only when we allow a desire for financial advantage to overcome our honesty, but when we so much as allow honesty and financial advantage to compete on the same playing field for our allegiance—that is, if moral norms really govern us.[14]

Claiming that moral norms are special, that they affect us in ways qualitatively different from other norms to which we offer allegiance, is not an uncontroversial claim. Since post-Galilean science has drained the world of immanent value, those of us educated in that tradition tend to presume that value is projected by us onto a neutral reality; and that any such values that we project must all be on a similar plane.[15] If moral values appear to be different than norms for skills, this must be an illusion. We care about truthfulness and honesty and we care about shooting a basketball skillfully. If failing at truthfulness seems more (or less) important to me than failing at basketball, then such a difference in my embracing the norm of truth or that of skill at basketball simply reflects my scale of values, such as it is. There's no more to be said and there's no reason to believe that the values we label as moral have a privileged character, any more so than for believing that one flavor of ice cream is somehow innately better than another.[16]

Yet the special quality of morality is attested to by a phenomenon peculiar to morality and central to concerns about professionalism, discussed by the ancient Greeks as the problem of *akrasia*—the problem being that although we see the morally right thing to do, we sometimes fail to do it.[17] For other skills, adequacy of vision is the main requirement for properly skillful action (presuming, of course, the possession of whatever ability the skill demands). Given the right training, we find no disconnect between seeing how to make a diagnosis and making it; between knowing how to prepare a dish skillfully and doing it; between seeing the opening in the lane and powering through it to make the shot. Moral vision, however, is sometimes not enough to produce moral action. Although moral demands are absolute, we sometimes see and acknowledge these demands only to go on and allow other considerations such as prudence or convention or pleasure or profit to compete with, and perhaps overcome, the demands of morality.

For those who would deny the special character of moral norms, akrasia may be illusory—the claim being that our actions reflect the preponderant balance of a multitude of conflicting judgments or desires, such that what we really want to do on balance, we do—so that if we fail to keep a promise in the face of what we thought was a commitment to keep them, then keeping promises was not as important to us as we thought, at least in the given situation.[18,19] Or we may see it as a conflict between imperatives that do not differ intrinsically in kind or weight,[20] in which case a conflict between a moral demand and the dictates of prudence or pleasure is like that of having to choose between two flavors of ice cream; a construal that is another way of denying the phenomenology of akrasia. It is more plausible to acknowledge that the Greeks did indeed detect a problem; that, unlike our relation to other skills, our moral reach sometimes does exceed our grasp; that we are both oddly prone to failing to live up to our moral vision and disappointed by such failure in a special way. Morality, that is, is sui generis; its claims are both absolute and sometimes very difficult.

For many medical educators, the analogy of professionalism to expertise implies similar approaches to their inculcation. Just as one can lead neophytes into the skills of assessing and treating the sick by abstractions followed by guided interaction with patients, so one can teach them to be moral people by didactic presentation of moral abstractions combined with in situ guidance as students grapple with the moral aspects of medical situations. The clinical teacher explains and coaches; the moral teacher does the same. And assessment of morality in medical trainees may be analogous to that of clinical skill: the teacher can test didactic knowledge of morality in examinations and on-the-job "competence" at it by observation, preferably of behaviors that can be assessed objectively—that is, reproducibly and without the medium of subjective interpretation.

Although Dreyfus's model may point to similar features in the acquisition of morality and medical skill, the special character of morality will preclude the success of exclusively academic approaches to its inculcation. In seeking professionalism in trainees, medical educators ought to be primarily concerned with akrasia rather than with

an initial inculcation of morality; most would agree that medical students are generally well intentioned at the outset of their education. The difficulty is not that medical trainees do not share high ideals of behavior for physicians; it is getting them to live up to these ideals, to which just about all would assent, when they encounter the stresses of medical practice, in training and afterward. Accordingly, the most important task of the would-be teacher of professionalism is not to convey moral abstractions but to reinforce the moral emotions that might sustain moral responsiveness in the middle of a long night on call or in moments of temptation, such as when a checkmark on a billing slip for a higher level of service than delivered might lead to markedly better reimbursement.

Unfortunately, the kind of emotion-laden moral responsiveness in question is of a different order than the kind of skillful perception involved in practicing clinical medicine or other skills directed at aspects of the world conceived scientifically. Our beliefs about disease in individual patients are modifiable in training, as we learn to see disease correctly because we come to share a conceptual framework and perceptual apparatus that focuses on a pathophysiology dispassionately considered and "out there" for all of us to see in the same way.

We may often (though certainly not always) agree on a given moral reality "out there" in any particular situation when that situation is considered at leisure; but our moral perceptions and responsiveness "on the fly," particularly under conditions of stress, are not modifiable by us or by others in the same straightforward way that we can correct misperceptions of disease states when our attention is called to them. Medical perception is like a pair of glasses we can adjust, put on, or take off, whereas the emotional component of moral responsiveness makes it more like an integral part of our visual apparatus. Simply being told to view a situation differently (and act accordingly) cannot make us see and respond other than as we do—without a deeper kind of change in our perceptual apparatus and its emotional concomitants than can be accomplished by cognitive instruction even when accompanied by supervised practice.

Education for Professionalism

If morality is an important part of professionalism and if it is as different from other cognitive and practical skills as I suggest it is, it follows that we cannot straightforwardly "learn" (or relearn) professionalism in most educational settings any more than we can become French by learning the language. The practical skills and abstract knowledge offered in colleges and professional schools are informative and task-enabling rather than soul-changing unless, that is, they are accompanied by more intensive and all-encompassing experience than most schools can offer. The formation of personal identity sufficient to achieve change in moral outlook is more likely to be accomplished under the purview of parents, the monastery or convent, the boarding school, or the Marines. Not that the subject matter of conventional education is not or cannot be formative of identity; but it does not usually have more than the germ of such effects during conventional periods of education. The abstract realms in which we are educated do not, at the outset, generally engage our deepest feelings and convictions about the world. The humanities are more likely to do so than the sciences, but most of us probably sit through our courses in history and literature, particularly the introductory ones, without having our hearts wrung or our opposition aroused. Such challenges are likely there in the material we are being asked to engage with, but we do not necessarily allow them to really come home to us, to work out their implications for our own approach to life; we do not take them to heart. Instead, we allow the material we are learning to remain on an abstract, conceptual level as we learn it to whatever extent that we do. Even if we can parrot and manipulate the concepts or particulars we've been studying well enough to excel academically, we likely leave such courses as we came into them, with perhaps only a seed implanted of possible deeper transformation, the fate of which will depend upon our future course and choices as our mental life progresses.

If we do allow ourselves to be challenged at deeper levels, we do not simply take in and exchange the assertions or emotions about the world on offer in the classroom or textbook for our own. Such challenges become the occasion for prolonged deliberation, colored by our ongoing experiences, in which emotion will play an important part. And, with the passage of time and the progression of feeling and thought, there may or may not be the beginning of a change in our moral responses. That is, changes in our moral opinions, if they are important changes, will take time to filter into our lived moral life—our largely automatic perceptions of and feelings about the moral aspects of situations as we face them.

Of course, such changes may begin suddenly; abrupt conversions do sometimes happen. But even then, the working out of the altered view of the world we take on occurs slowly; it must seep into our responses to people and life and events over time. It cannot be what it will finally become without the ongoing interplay with the world by which we become ourselves. And, of course, not all conversions "take." Whether beginning quickly or slowly, changes in thinking and feeling deep enough to affect our moral attitudes may progress over time until we look back and see that they have fully developed and that we are different people than we had been. Or such development may arrest at any point, and our direction may alter—as our choices over time will determine.

Insofar as we wish medical trainees to take on morality (if they do not have it already), we are asking for a kind of personal transformation rather than for the cognitive play among abstractions that most education can foster. Accordingly, we are in the realm of boarding schools and the Marines rather than that of conventional higher education. Conveniently for those of us who wish to inculcate professionalism, medical education has its analog to the Marines: internship and residency. As in any such formative experience, trainees are subject not merely to a curriculum but to a new way of life. As they learn the more conventional skills of assessing and treating the ill, they also come to appreciate and either take on or, perhaps, reject the moral vision of their colleagues and mentors. Unfortunately for professionalism, the moral tone of academic medical institutions frequently subverts rather than supports the development of good professional morals, and such moral influence as it has exerted on trainees likely has been as

much malign as beneficial; although trainees often recover from the malign effects.[21–23]

Presuming that internship and residency are indeed the proper setting for the inculcation of professionalism, what can medical teachers in that setting do to make it happen? First, perhaps, we must examine ourselves. The moral tone of academic medical centers is set from above, and trickles down to the level of trainees. Our attitudes and behaviors have a profound effect on our junior colleagues, for good or ill. We must ensure that we ourselves are living the kind of lives we wish to encourage among our juniors for our efforts at promoting professionalism to have any hope of success.

If my analysis of the differences between morality and expertise is correct, didactics and coaching of the sort that suffices to teach clinical medicine will not inculcate professionalism. Medical educators must proceed instead by setting out our expectations and then instantiating them, making our lives on the ward a tacit invitation to our trainees to follow in our footsteps. Such expectations ought not to be offered as a recitation of the Physician's Charter[24] or ACGME standards. Instead, an attending physician might allude to the stresses that he, along with the housestaff, will undergo during the month and make the point that he will hold himself to a professional standard that he will also expect the housestaff to achieve—when patients are difficult, when admissions are unreasonable, when other services are unhelpful, and when it gets impossibly busy. He might go on to tell the team that he will challenge them for observed shortcomings of professionalism, but that he opens himself to similar challenges from them. In the day-to-day work of the ward team, professionalism will be primarily exhibited rather than discussed, although the mindful attending will occasionally find opportunity to focus explicitly on good or bad examples of professional attitude and behavior.

Over the first year or so of training, those attendings who work closely with many residents will begin to get a sense of their moral personas. As in many other areas of personal development, the needs and aptitudes of individual trainees will differ. Of those who need to develop morally, some will benefit from being gently led while others may require the metaphorical kick in the pants. When the needs of individual trainees are sufficiently clear to the program director, perhaps early in the second year of training, assigning trainees to suitable individual faculty for mentoring may help achieve appropriate direction for residents that would not happen from the month-to-month role-modeling of different attendings alone.

To credibly offer explicitly moral direction to trainees, attendings themselves will have to be willing to submit to moral evaluation. Their performance can be assessed by feedback from housestaff who work closely with them, preferably collected in the form of personal interviews. Over time, the program director will get a sense of attendings' professional performance as vivid as that which she achieves about her residents whom she comes to know well. Thus high standards of professionalism may be set for allowing attendings to attend no less than for allowing residents to progress in their training.

I suggest a need for personal and narrative assessments of professionalism rather than objective assessment because of the failure of moral perception and action to fit into a realm of law analogous to human disease. Knowledge of medical abstractions and skill at diagnosis can be scrutinized objectively, because instances of disease can be captured adequately from the impersonal, "sideways-on" perspective that allows intersubjective agreement without subjective participation. Moral perception cannot dispense with subjectivity in this way. Because the terms of morality do not supervene upon neutrally descriptive language in any law-like manner (or do so only in a manner offering no explanatory interest),[25] no such objective description of human action in neutral terms will capture its moral aspects—any more than description of illness at the level of biochemistry can tell us how sick a patient feels. If we are observing a moral agent, we need to imaginatively participate in that agent's perspective to appreciate it, and we can morally assess such a perspective only by bringing to bear our own moral imagination. Saying "the student acted compassionately" is a subjective judgment, but it captures the moral aspect of the student's action. Saying "the student grasped the patient's hand and smiled" is intersubjectively verifiable, but fails to identify the specifically moral character of the student's action. Precisely insofar as observation and assessment are limited to objective "behaviors" is moral assessment thereby excluded. The student indeed grasped the patient's hand and smiled, but did the gesture convey compassion or malice? Only the observer already possessing morality and able to imaginatively participate in the student-patient interaction can tell. The moral reality cannot be pulled apart from the world subject to law in which it has its being,[26] and moral interpretation, and thus assessment, of action must therefore remain subjective to be valid.

Subjective assessment, of course, has its own set of difficulties. But it may be that we have to choose between the kind of reproducibility (and avoidance of bias) usually associated with objective assessment and validity in the assessment of professionalism, in which case we ought to choose to truly assess what we are interested in as best we can. Loss of objectivity in this case may, however, be no bar to intersubjective agreement so long as assessors of professionalism share a common moral outlook in regard to it. If we educators see the moral aspects of trainee action on the wards similarly, then we will agree as to what constitutes respect for persons, compassion, integrity, and honesty in the clinical setting and we will agree as to when trainees are succeeding or failing in professionalism. We ought nevertheless to avoid the use of scales or standards that presume the possibility of objectively comparing trainees on dimensions of professionalism.

Even the virtuous observer will not always be able to distinguish committed observance of moral norms from mere compliance with them for prudential reasons such as getting a good grade. This limitation is consistent with our legitimate expectation of compliance, and with what can be no more than our hope of achieving observance in the longer term.

Attendings can provide narrative assessments of professionalism for trainees as the latter can do for attendings. But attendings' contact with trainees is limited. It is especially

important for residents to be scrutinized during periods of stress; thus nurses and other staff who work with residents during their call nights may provide useful assessments, as could unannounced trained standardized patients in the resident outpatient clinic. What is unlikely to be of use are attempts to assess professionalism during artificial situations such as objective structured clinical examinations, useful as these may be for other purposes—presuming that we are interested in assessing moral attitudes, which can easily be disguised, rather than interpersonal skills.

Even given moral attendings and a sound program of encouraging and assessing professionalism, we must be clear on how far we can expect to develop professionalism in our internship and residency trainees. Unlike formal mastery of abstract concepts or satisfactory performance of task-specific skills, the state of being governed by moral norms cannot be brought about by a simple decision on the part of the trainee to be so governed followed by a limited period of cognitive engagement and practice. That is so even presuming wholehearted concurrence on the trainee's part, which cannot be presumed for moral norms proffered to trainees as it can for norms of excellence for medical practice. Reading Harrison's *Textbook of Medicine* may be engaging or wearisome, but the medical abstractions contained therein, part of the impersonal realm of law, do not engender the kind of wariness that must attend assertions about desirable moral attitudes and emotions. As with reading corporate mission statements, reading the Physician's Charter is perhaps as likely to elicit skepticism as inspiration. Our moral attitudes and emotions are what they are, and, as with other deeply ingrained attitudes, cannot be altered in a moment either by us or by others. If, in fact, they are to change, they will do so gradually through a complex process of volition and action and emotional engagement over time.

As medical educators set out expectations, and act as models and mentors, such change as actually occurs will be each trainee's response to the tacit invitation conveyed by our lived moral life over time; such a response cannot be commanded or obtained by instruction that infers internalization and lasting adherence from initial outward compliance. The kind of instruction following from the analogy of professionalism to expertise is likely to create in trainees a sense of manipulation—because "teaching" professionalism as a skill like clinical medicine presumes the possibility of effecting what, to be successful, would have to be personal transformation—the shaping of individual moral identity—through a relatively brief, self-conscious process of training. It is not only impossible; it is belittling to presume that medical students and residents are so impressionable and malleable and unformed as to become "professional" (moral) through such a process. They are not plastic to be molded; they are moral agents who may be exposed to and engaged by a moral approach, which they may already share or may go on to embrace or reject over years of reflection and experience. We can and must elicit compliance with moral (professional) norms as medical teachers, even if we cannot be sure of eliciting commitment to them or governance by them.[27] If our trainees do not find our moral instruction or our good moral example to be persuasive, we can still demand that they be kind to patients and conscientious about their work. Trainees may comply with our wishes not because they are committed to professionalism, but because they need to get through our rotation or because it is easier to get along by going along. And if this is the best we can get from our trainees, we must take it, even as, by precept and example, we ask for deeper commitments.

Summary

I have suggested that professionalism is best thought of as medical morality, and that as such, professionalism indeed resembles forms of expertise such as medicine in important respects. The analogy of professionalism to expertise is limited, however, by the unique character of moral norms. Their presence or absence forms our character prior to the intervention of higher education; they assume a unique authority, governing us in a manner that silences other norms that might compete with them; and to whatever degree they are present or absent, their emotional concomitants give them a place in our repertoire of modes of apprehending the world that other kinds of task-based skills can seldom rival. They cannot be doffed or assumed as we can put on or take off the various hats we wear as purveyors of this or that expertise, even professional skills acquired over years of training.

Thus, although medical educators can teach professionalism, especially during internship and residency, we are mistaken to suppose that we can do so as readily as we teach clinical medicine or that we can expect professionalism to appear as automatically as clinical skill and judgment begin to in third- and fourth-year students and junior residents. Nor can we unproblematically assess its presence as a "competence" that trainees have achieved and that they will continue to possess. In thus throwing cold water on the ambition of the ACGME to make of professionalism one more "skill" that medical education can develop, polish, and scrutinize, I do not wish to suggest that we cannot encourage professionalism and perhaps obtain it in many if not most trainees. But I believe we are more likely to do so if we see professionalism clearly as an aspect of personal identity and character that must develop, if not already present, from an even deeper kind of commitment over time than trainees must give to the acquisition of skills necessary for medical practice.

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Cover Note

The University of Mississippi Medical Center

The 1955 opening of the University of Mississippi Medical Center and four-year School of Medicine (SOM) in Jackson was the culmination of hopes half-a-century old. Medical educators on the university campus at Oxford, which had housed a two-year program of medical education since 1903, were the first to realize that the two-year school could not produce enough physicians to meet Mississippi's health care needs.

"The two-year school amassed an excellent track record in the number of its students who were accepted as juniors into some of the country's finest medical schools," said Dr. Daniel W. Jones, vice chancellor for health affairs and dean of the SOM. "But too many of the students who left the state to finish their education never returned to practice."

As early as 1905, just two years after the first students enrolled in the two-year medical program at Oxford, faculty member Dr. Peter B. Rowland voiced the dream of a clinical training site to complete the basic sciences curriculum at the University of Mississippi. "It is my deliberate judgment," he said, "that the legislature should construct a . . . hospital in . . . Jackson to be owned by the University of Mississippi, for clinical instruction, thus giving us a full four-year medical college in this state."

But it was not until the late 1940s that the Mississippi State Medical Association, Governor Thomas Bailey, and interested legislators and educators began seeking support for a four-year medical school. Their efforts met with little success at first, but they set the stage for the dramatic—and successful—campaign for the Medical Center in 1950. During the legislative session of that year, Representative Zelma Price of Greenville was wheeled onto the floor of the House of Representatives on a stretcher to vote for the establishment of the Medical Center. The legislation ultimately passed, authorizing the expansion of the medical school into a four-year institution and the building of the teaching hospital in Jackson.

This year marks the 50th anniversary of the Medical Center and the four-year SOM. What began as a small teaching hospital and medical school has become a major academic health center housing four other schools and four teaching hospitals. The faculty's pioneering work in heart and lung transplantation and in cardiovascular dynamics is recognized internationally. The Jackson Heart Study, the largest and most comprehensive study of cardiovascular risk factors in African-Americans ever undertaken, is based here, and the Medical Center is also home to *Guyton's Textbook of Physiology*, one of the most widely used medical texts in the world. In keeping with the Medical Center's commitment to serving the health care needs of Mississippi and advancing the general understanding of the life sciences, the Medical Center will break ground on an addition to the Arthur C. Guyton Laboratory Research Complex this fall. When the building is completed, it will house 180,000 square feet of new dedicated research space. The complex designation honors the late Dr. Arthur C. Guyton, the internationally known physiologist, who was the SOM's first chair of physiology and biophysics.

Since 1957, 4,556 physicians have earned their degrees in Mississippi's SOM, and, true to the vision of the institution's founders, they're helping to meet the state's health care needs. More than 60 percent of the graduates who've completed their training practice in Mississippi today.

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