HOW DO MEDICAL STUDENTS LEARN PROFESSIONALISM AND DEVELOP PROFESSIONAL IDENTITIES? AN INSTITUTIONAL ETHNOGRAPHY OF THE CURRICULUM AT ONE MEDICAL SCHOOL

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In Partial Fulfillment of the Requirements
For the Degree of Philosophy
In the Department of Sociology
University of Saskatchewan
Saskatoon

By
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ABSTRACT

Professionalism and professional identity are becoming central topics in educating tomorrow’s physicians. This dissertation is an institutional ethnography of the curriculum on professionalism and professional identity at one medical school. By examining the three types of curricula – the formal curriculum, the informal curriculum, and the hidden curriculum – and highlighting the gaps between them, this study provides a detailed account and an explanation of medical students’ learning experiences with professionalism and professional identity.

Utilizing the methodology of IE, I conduct document analysis, participant observation, and in-depth interviews with medical students and faculty to reveal institutional practices, identify social relations, and describe students’ learning experiences. I apply a combination of Giddens’s structuration theory of understanding the complexity of social practice, and Lave and Wenger’s understanding of the context of social practice – community – to analyze the processes and consequences of students’ development of professionalism and professional identity formation in medical education.

In pre-clerkship, the medical school’s institutional practices of narrowly defining professionalism and equating the concept to student professionalism and professionalism in professionals is not effective in transformative learning to support students’ development of medical professionalism and professional identity formation. Clerkship is a more significant stage of learning of professionalism and professional identity formation as students’ immersion in the community of medical practice provides not only explicit but also tacit knowledge to master the practice of medicine. Through legitimate peripheral participation in a situated learning environment, students develop a more realistic understanding of medical professionalism and physician roles and develop a specialty-defined professional identity.

Many changes have been made to the formal curriculum and, to some extent, the informal curriculum in medical education to support students’ learning of professionalism and development of a professional identity that performs more roles than simply the medical expert. However, the gap between what students are taught in classroom and what they observe and are taught in practice is still significant. Medical students continue to develop and negotiate their professional identities in the context of competing discourses where the other physician roles often lose the battle to the role of medical expert.
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DEDICATION

To my mom and dad,
never judgmental, forever supportive

And to my little brother,
a best friend for life
TABLE OF CONTENTS

PERMISSION TO USE ........................................................................................................ i
ABSTRACT ........................................................................................................................ ii
ACKNOWLEDGEMENTS ................................................................................................... iii
DEDICATION ...................................................................................................................... iv
TABLE OF CONTENTS ..................................................................................................... v
LIST OF ABBREVIATIONS ................................................................................................. ix

CHAPTER 1 INTRODUCTION ............................................................................................. 1
  1.1 Introduction ................................................................................................................. 1
  1.2 Research Contexts ....................................................................................................... 2
  1.3 Research objective, research questions, and research design .................................... 4
  1.4 Outline ....................................................................................................................... 6

CHAPTER 2 LITERATURE REVIEW ................................................................................... 8
  2.1 Introduction ................................................................................................................. 8
  2.2 Literature search and review strategies ...................................................................... 8
  2.3 Professionalism in medicine and medical education .................................................. 9
      2.3.1 The nature and function of professionalism in medicine ................................... 9
      2.3.2 Medicine’s professional crisis and modern-day professionalism movement ....... 11
      2.3.3 The definitional issue of professionalism ......................................................... 13
      2.3.4 Changing definitions and understanding of professionalism ........................... 15
      2.3.5 Teaching and learning of professionalism in medical education ..................... 17
  2.4 Professional identity in medicine and PIF in medical education .............................. 20
      2.4.1 Importance of professional identity in medicine .............................................. 21
      2.4.2 PIF in medicine ............................................................................................... 23
      2.4.3 Changing dynamics in physicians’ professional identity .................................. 26
      2.4.4 Facilitating PIF in medical education ............................................................... 28
  2.5 The concept of curriculum in medical education ...................................................... 30
  2.6 Literature review summary ....................................................................................... 34
      2.6.1 Progress and challenges in teaching/learning professionalism and developing professional identities in medicine ............................................................. 34
      2.6.2 The relationship between professionalism and professional identity in medicine .......................................................... 36
      2.6.3 Literature review conclusions ......................................................................... 38

CHAPTER 3 THEORETICAL FRAMEWORK .................................................................... 39
  3.1 Introduction ................................................................................................................. 39
  3.2 The development of the sociology of medical education – a theoretical review ....... 39
  3.3 Theoretical significance of the study – sociology’s contribution to medical education ... 42
  3.4 Structuration theory and tacit knowledge ................................................................. 43
3.6 Summary of theoretical framework ........................................................................... 49

CHAPTER 4 METHODOLOGY ......................................................................................... 50
4.1 Introduction ........................................................................................................... 50
4.2 Overview of research methodology ..................................................................... 50
4.3 Theoretical considerations of IE ........................................................................... 51
4.4 Data Collection ................................................................................................... 52
  4.4.1 Document collection ....................................................................................... 53
  4.4.2 Participant Observation .................................................................................. 54
  4.4.3 In-depth Interviews ......................................................................................... 55
4.5 Data Analysis ....................................................................................................... 57
  4.5.1 Thematic analysis ......................................................................................... 58
  4.5.2 The concept of discourse in IE ....................................................................... 58
  4.5.3 Mapping social relations and social organization of learning environment .... 59
4.6 Methodology summary ......................................................................................... 60

CHAPTER 5 FINDINGS PART 1 – LEARNING PROFESSIONALISM AND TRANSITIONING TO
MEDICAL STUDENT IDENTITY IN PRE-CLERKSHIP .................................................. 61
5.1 Introduction ......................................................................................................... 61
5.2 Learning professionalism in pre-clerkship............................................................ 61
  5.2.1 Student professionalism and professionalism in professionals .................... 62
    5.2.1.1 Formal curriculum .................................................................................. 63
      5.2.1.1.1 Statements – ideals of professionalism and a clear pathway ......... 63
      5.2.1.1.2 Policies and procedures – the CoM’s professionalism policy ........ 66
      5.2.1.1.3 ‘Orientation and Professionalism’ module – introduction to the concept of professionalism ................................................................. 71
    5.2.1.2 Informal curriculum ................................................................................. 72
      5.2.1.2.1 Teaching professionalism in policy form ..................................... 72
      5.2.1.2.2 Handling incidents of breach of professionalism ....................... 74
      5.2.1.2.3 Identifying the collective impact of unprofessional behaviour ...... 76
    5.2.1.3 Hidden curriculum – lived experiences of professionalism policy for students ................................................................. 79
      5.2.1.3.1 A culture of fear – learning not to be unprofessional ................ 80
      5.2.1.3.2 Expected to be professionals but treated as children – not given the space to be professionals .......................................................... 82
    5.2.1.4 Summary of 5.2.1 ..................................................................................... 84
  5.2.2 Medical professionalism and physician roles ................................................... 85
    5.2.2.1 Formal curriculum .................................................................................. 86
      5.2.2.1.1 Classroom teaching of medical professionalism and physician roles – M&S ................................................................. 86
      5.2.2.1.2 Experiential learning opportunities in pre-clerkship ................. 87
        5.2.2.1.2.1 Experiential learning modules in M&S ................................ 87
        5.2.2.1.2.2 Shadowing in SinMS .............................................................. 89

vi
7.3 Community of practices, tacit knowledge, and identity formation ........................................... 171
7.4 Knowledgeability, power relations, and structuration ............................................................. 176
7.5 Moving forward – the place of professionalism and professional identity in medical education ................................................................. 183
7.6 Contributions and limitations .................................................................................................. 185
7.7 Conclusions .............................................................................................................................. 188
References ........................................................................................................................................... 189
Appendix A CoM Ethics and Professionalism Document ................................................................. 213
Appendix B CMA Code of Ethics and Professionalism ................................................................. 220
Appendix C CoM MD Program Learning Objectives ...................................................................... 226
Appendix D CoM Standard Operating Procedure-Undergraduate Medical Education:
Procedure for Concerns with Medical Student Professional Behaviour ..................................... 229
Appendix E CoM Undergraduate Medical Education Program Informal Discussion Form ......... 242
Appendix F CoM Undergraduate Medical Education Program Professionalism Concern Form .............................................................................................................. 244
Appendix G CoM Procedure Flowcharts for Concerns with Medical Student Professional
Behaviour (Minor Incident, Major Incident, and Critical Incident) ................................................. 247
Appendix H CoM Undergraduate Medical Education Assignment Submission Policy ................. 249
Appendix I.1 CoM MD Program Pre-clerkship Attendance and Absence Policy Overview ...... 252
Appendix I.2 CoM MD Program Clerkship Attendance and Absence Policy Overview .......... 264
### LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ABIM</td>
<td>American Board of Internal Medicine</td>
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<tr>
<td>AP</td>
<td>Academic professionalism</td>
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<td>CMA</td>
<td>Canadian Medical Association</td>
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<tr>
<td>CoM</td>
<td>College of Medicine</td>
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<tr>
<td>CSLP</td>
<td>Interprofessional Community Services Learning Program</td>
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<td>CWCLE</td>
<td>Community &amp; Workplace Centred Learning Experiences Module</td>
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<tr>
<td>DSAAP</td>
<td>Diversity and Social Accountability Admissions Program</td>
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<tr>
<td>EC</td>
<td>Experiences in the Community Module</td>
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<tr>
<td>IE</td>
<td>Institutional ethnography</td>
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<tr>
<td>LIC</td>
<td>Longitudinal Integrated Clerkship</td>
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<tr>
<td>M&amp;S</td>
<td>Medicine &amp; Society</td>
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<td>MD</td>
<td>Doctor of Medicine</td>
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<td>MP</td>
<td>Medical professionalism</td>
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<td>MTL</td>
<td>Making the Links/Certificate in Global Health</td>
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<td>PFCC</td>
<td>Patient- and family-centered care</td>
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<td>PIF</td>
<td>Professional identity formation</td>
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<td>SDOH</td>
<td>Social determinants of health</td>
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<td>SinMS</td>
<td>Success in Medical School</td>
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<tr>
<td>SLIC</td>
<td>Saskatchewan Longitudinal Integrated Clerkship</td>
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<td>SMSS</td>
<td>Student Medical Society of Saskatchewan</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedure – Undergraduate Medical Education: Procedure for Concerns with Medical Student Professional Behaviour</td>
</tr>
<tr>
<td>UGME</td>
<td>Undergraduate Medical Education</td>
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<td>UofS</td>
<td>University of Saskatchewan</td>
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CHAPTER 1 INTRODUCTION

1.1 Introduction

The idea that physicians need a professional identity to become effective practitioners of medicine is not new (Merton, 1957). However, medical education in the 21st century is predominantly structured in accordance with two separated but increasingly integrated components – basic science and clinical training – to prepare medical students with the required knowledge and skills. There has been growing recognition that medicine is practiced by and on people and that medical care happens in socially and culturally diverse contexts over the past few decades. As a result, the nature of medical professionalism and the best approaches to teach and assess it have received extensive attention. A quick scan of the themes of the Canadian Conference on Medical Education for the last ten years reveals an underlying awareness of the need for change and transformation, the complexity of the interplay between self and system/society, and the crucial role of humanism and accountability in health care. Including the teaching of professionalism as an important component in the medical curriculum is one of the responses to reform the medical profession in the context of increasingly complex health care systems and public’s concerns about the medical profession. Both complaints about the performance of some individual physicians and claims that the medical profession is failing to fulfill its professional obligations to society pose threats to the legitimacy of the profession as a whole.

As these changes are occurring, medical educators are confronted with the additional challenge of addressing more directly the concepts of professional identity and socialization. As Cruess and Cruess (2015) put it, teaching professionalism represents a means to an end, with the end being the formation of a professional identity. Identity is closely tied to education in medicine as trainees not only learn a body of knowledge and technique but also achieve a sense of themselves being members of a distinct profession with its defined social roles, specific understandings, and distinctive practices (Sullivan, 2016). In arguing the significance of the values and attitudes that physicians hold, Inui (2003) comments:

In the end, it is not because we have special knowledge and technology that we can be trusted – instead, we are trusted only if this knowledge and technology is firmly attached to values that are explicit, understood, and (when push comes to shove) altruistic. We not only need to be trusted, we need to deserve the trust of our patients and the public. (p. 14)

For the values of medicine to survive and evolve according to changing social contexts, they need to be consciously fostered and effectively transmitted (Ludmerer, 2015).

Paralleling the focus on professionalism and professional identity in medical education, it is also recognized that not all of what is taught can be captured by course syllabi, lecture handouts, or documents prepared during accreditation reviews (Hafferty, 1998). This has resulted in medical educators and researchers shifting their attention from the formal curriculum to other elements that influence the outcomes of medical education. These elements are generally identified in the
literature as the informal curriculum or the hidden curriculum (Hafferty, 1998; Michalec & Hafferty, 2013; O’Donnell, 2014). There is a highly interpersonal form of teaching and learning that takes place in medical schools. Some of these informal and hidden elements are often overlooked by the insiders to the medical profession, who utilize the taken-for-granted knowledge to manage daily activities and interactions in a hierarchical institution. The inherent and constantly reproduced medical culture and structure, to a large extent, remain unexamined in the medical education literature. Through examining the different types of curricula on professionalism and professional identity, this study seeks to understand students’ learning experiences with these two topics and how their learning experiences and the outcomes of their learning, and the institutional practices of teaching are interdependent.

Related to the topic of this study, the analysis of the significance of professionalism and identity to professional groups, of which medicine is one of the most commonly cited cases, is deeply rooted in sociological work not only in relation to theoretical development but also empirical research (Abbott, 1988; Carr-Saunders & Wilson, 1933; Freidson, 1970, 1974; Parsons, 1951). Applying sociological theories to understand the mechanisms of medical education could provide explanations to certain experiences and phenomena in medical training. It could also shed light on many issues central to sociology, including the construction of knowledge and professional values, socialization of professional groups, professional regulations, and the interplay between individuals and society in the establishment and maintenance of professions (Brosnan & Turner, 2009).

Professionalism defines the social contract between medicine and society. It provides a normative system that establishes the role and function of the medical profession and organizes the delivery of health care (Wynia, 2014). It is also a motivational force for members of the profession to define, uphold, and enforce the shared competencies and values (Wynia, 2014). The insights on the socially constructed nature of professionalism from the sociology literature guide the analysis of medical schools’ institutional practices on teaching of professionalism. A physician’s professional identity is a representation of self that internalizes the norms and values of the medical profession through training and practice (Cruess et al., 2014). Understood from the approaches of structuration theory and the theory of community of practice, medical education is a process and a social practice. The community of practice theory is utilized to explain the interactive nature of medical education and medical students’ active participation and negotiation of meaning and identity in the communities. The structuration theory informs the understanding of the power of a hierarchical structure and rules in guiding behaviour, structuration of dominant professional knowledge and values, and the profession’s resistance to change. The two theoretical approaches complement each other in revealing the complex dynamics in medical training that serve the functions of both education and social control.

1.2 Research Contexts

The medical profession is currently facing an explosion of technological developments, enormous knowledge advancement, challenges in health care delivery, and increasing activism from patients and society. Health care reforms, combined with demographic shifts, continue to pose
challenges for the medical profession as physicians find it increasingly difficult to fulfill their responsibilities to patients and society. Under these changing circumstances, it is more than necessary to revisit the concept of professionalism in order to define physicians’ responsibilities and find best approaches to meet those responsibilities. From within the medical education community, faculty are expressing dissatisfaction with the kind of doctors that medical students are becoming in different aspects (Frost & Regehr, 2013). These include diminished interest in primary care (Larson, Grumbach, and Roberts, 2005), unwillingness to work in underserved and rural areas (Curran & Rourke, 2004; Strasser, Hogenbirk, Lewenberg, Story, and Kevat, 2010), and declining professionalism, empathy, and compassion (Nivet, 2011; Smith, 2005). Medical schools and teaching hospitals are central to preparing medical trainees to adequately perform the physician roles (Nivet, 2011).

Holden et al. (2015) argue that the foundation of education of all medical students lies in professional identity formation (PIF), which they define as: “the transformative journey through which one integrates the knowledge, skills, values, and behaviors of a competent, humanistic physician with one’s own unique identity and core values” (p. 762). The approaches that medical students take to develop their professional identities and consequently conceptualize the relationship between personal and professional identities have significant implications for their wellness and the relationship that they build with other health care professionals and patients (Monrouxe, 2010). PIF plays a fundamental role in foraging students’ professional values and behaviours and internalizing the profession’s ethical and moral duty to the welfare of patients (Cook et al., 2010). Rather than instilling fixed norms into trainees, the process and the anticipated outcome of transformation in identity could support them to be adaptive and better prepared to work in a health care system that is constantly evolving, and engage with technological and social advancement to meet the changing health care needs (Kline et al., 2020).

General principles and specific programs, which collectively address factors of role modelling and mentoring, experiential learning and reflection, faculty development, interprofessional collaboration, assessment, and continuum of progress, have been established over the past two decades to support teaching on professionalism in medical schools and facilitating medical students’ PIF (Cruess et al., 2016). Despite the huge amount of literature produced over the past two decades, professionalism remains elusive with respect to how it is embodied through the lived experiences of medical students. There is little research on students’ perception of professionalism and the facilitators and barriers that they encounter in PIF (Maitra et al., 2021). Similarly, while it is known that learners perceive clinical teachers as role models and consider them to be critically important for their PIF, the perspective of clinical teachers and preceptors is rarely explored. A study conducted in 2020 was one of the first to understand PIF from the clinical teachers’ perspective and revealed that supporting clinical teachers to engage in difficult conversations and make the implicit knowledge explicit is crucial to achieve the goal of facilitating medical students’ PIF (Sternszus et al., 2020). Though there is room for improvement on best practices to facilitate the learning on professionalism and PIF, there is consensus that the enculturation to medical professionalism and the process of PIF should no longer be left to chance. They should, instead, be explicitly nurtured through initiatives in medical education curriculum and systematic support (Kinnear et al., 2021).
In medical education, the discourse of professional identity is trying to catch up with the dominant discourse of competency as it is increasingly being argued that medical students can and should have both through their training (Parson et al, 2021; Sawatsky et al., 2020). However, tension between the two still exists when the competency-based education, which is proposed to provide formative and low-stake assessments, is perceived by medical trainees as high-stakes evaluations that have serious consequences (Sawatsky et al., 2020). This could significantly encourage staging competence and concealing perceived weakness, which hinders opportunities for mentorship and growth (Sawatsky et al., 2020). Within pedagogies, medical schools are trying to develop programs that could foster a coaching relationship between instructors and students, which promotes coaching conversations that support life-long learning and PIF (Parson et al, 2021; Sawatsky et al., 2020).

Medical educators are also seeking expertise from and collaboration with other health care professionals and patients and caregivers to support medical students’ PIF so they are equipped to provide patient- and family-centred and interprofessional care (Clark, 2014; Stull & Blue, 2016). For example, a pilot study found that through learning with students from other health professions and from patients or caregivers, who serve as mentors, medical students started to recognize patients as autonomous and experts, and their own role as partners and collaborators (Kline et al., 2020). Patient and caregiver mentors help students develop a professional identity that commits to partnership with patients, holistic approach to care, and interprofessional collaboration (Kline et al., 2020). This further underlines that collaboration among the patient, caregiver, and an interprofessional team of health care providers is at the core of patient- and family-centred care (Stull & Blue, 2016). The professional identity that students develop, along with their perceptions of the role of patients and caregivers, and other professions in health care, directly affect how they approach medical practice and provide care when they go into practice. However, it is argued that the current approach of teaching on these topics serves the purpose of ticking boxes instead of providing meaningful and transformative learning opportunities (Joynes, 2017).

Despite the enormous efforts and progress, the current approaches of teaching professionalism and fostering professional identity have been criticized for their focus on remediating negative professionalism, oversimplification of complex content, isolating the cognitive base from the clinical context, insufficient positive role modelling, and inadequate focus on the individuals or periods of transition (Sternszus, 2016). Improvement on these areas depends less on reform on the formal curriculum but more on the informal or hidden curriculum, which relies on tacit knowledge that is delivered and learned through interactions (e.g., verbal conversations or non-verbal observation) between students and other groups of participants in the communities of medical practice and medical education. To utilize informal or hidden curriculum to support the learning of professionalism and PIF requires the recognition of situated learning that is crucial to medical education, especially clerkship, and teaching and learning as a social practice.

### 1.3 Research objective, research questions, and research design
This project builds on previous literature on the nature and process of medical education, which often either lacks empirical data to test the applicability of theoretical approaches adopted to advocate for change for curriculum reform, or simplifies the social practice of teaching and learning and does not take into account the lived experiences of participants or the impact of structural factors on teaching and learning. The purpose of this study is to conduct an empirical study and adopt a critical sociological perspective to understand medical students’ learning experiences with professionalism and professional identity, with attention to not only the formal curriculum, but also the informal curriculum and the hidden curriculum. The formal curriculum establishes the learning objectives, the content, and the evaluation criteria of the arranged courses. The informal curriculum represents how the objectives and content of the courses are delivered in a classroom or clinical setting. The hidden curriculum signifies what medical students learn incidentally from the institutional culture, role models, the power relations at medical school and in health care system, and the curriculum gap between the formal and informal curricula. The formal, informal, and hidden curricula are all essential parts of the overall curriculum delivered to medical students and make an impact on their experiences going through medical training.

This study has three main objectives: (1) to understand how the two interrelated aspects, the learning of professionalism and PIF are influenced by concrete learning environments and processes as well as by various participants within the medical education field; (2) to provide some detailed accounts of medical students' learning experiences; (3) to reveal the conflict and lack of alignment between the formal curriculum (what medical educators intend to teach), the informal curriculum (what medical educators actually teach), and the hidden curriculum (what medical students actually learn). The findings will then provide some practical suggestions, at both institutional and individual levels, to (1) make the formal curriculum, the informal curriculum, and the hidden curriculum align with each other; and (2) maximize medical educators' efforts at teaching professionalism and medical students' efforts at developing professional identities.

To achieve the research purpose and meet the research objectives, this study utilizes the methodology of institutional ethnography (IE) to gather and analyze three types of curricula in medical education and tries to answer two main research questions: how medical students learn professionalism and how medical students develop professional identities. It also tries to untangle the relationship between medical students’ learning of professionalism and their formation of a professional identity. IE moves beyond individual explanations of a phenomenon and reveals the institutional order and social relations that organize people’s everyday life (Smith, 2005). This study seeks to reveal important mechanisms that are at play in medical education and provide explanations to these mechanisms by discussing the social/institutional construction of knowledge, especially the development of dominant and legitimate knowledge in a given field, the production of positionality and its relevance to identity formation, and the structuration of a hierarchical working/learning environment and professional values.

This study gathers data on institutional policies and procedures, course syllabi, and other types of texts, and conducts participant observation of pre-clerkship courses and interviews with
medical students and faculty. Through utilizing content analysis and mapping learning opportunities and social relations, this study uncovers the significant learning mechanisms in medical education and groups of participants who contribute to these learning mechanisms. By emphasizing the impact of texts, which are explicit knowledge, and situated learning in communities, which delivers tacit knowledge, on students’ learning experiences with professionalism and PIF, and applying the theoretical understandings of structuration theory and community of practice theory, the study highlights curriculum gaps, resistance to change, and the missed opportunities to support students’ personal and professional development in medical education.

1.4 Outline

In this introduction chapter, I set the context for this research study, briefly discuss the research objectives, questions, and design, and provide an overview of the structure of the thesis. In the next chapter I present a literature review, drawing upon research in the fields of both sociology and medical education. I review the current understanding and knowledge of professionalism, professional identity, and the different types of curricula in medical education. In chapter three, I describe the theoretical framework for this study, which includes two theoretical approaches – structuration theory and community of practice theory – that complement each other in analyzing the research findings and answering the research questions. I highlight the key theoretical concepts and how they will be applied to understand the processes and outcomes of medical education. Following this, I introduce the methodology utilized for this study, which is an institutional ethnography of the curriculum. In this chapter, I connect the methodology of IE and its theoretical understanding to the theoretical framework in this study, define the formal curriculum, informal curriculum, and hidden curriculum in this study, and describe the approaches of data collection and data analysis.

The research findings in this study are divided into two chapters. The first of these provides analysis and research results focused on students’ learning experiences with professionalism and professional identity in pre-clerkship medical education. Three types of professionalism are discussed in relation to the impact of the respective formal, informal, and hidden curriculum. At the end of the chapter, the identity of medical students is discussed, especially the mechanisms that contribute to the construction of that identity. The second research findings chapter presents research results on clerkship medical education. Because of the self-directed nature of clerkship, which is structured according to core and elective rotations, following an introduction of the formal curriculum, the chapter presents the learning mechanisms of professionalism and PIF that participants identified. The last chapter of discussion and conclusions utilizes the theoretical framework to understand the research findings collectively, highlighting the relationship between the three types of curricula and curriculum gaps, and emphasizing the socially constructed nature of professionalism and the formation of professional identities in communities of practice. Through identifying the resistance to change in working/learning environment and the impact of institutional practice on medical students’ learning experiences with professionalism and professional identity, the last chapter also provides some practical
implications of the research findings. Lastly, I discuss the contributions and limitations of this study before providing the conclusions.
CHAPTER 2 LITERATURE REVIEW

2.1 Introduction

This literature review chapter is divided into five sections. First, I provide an overview of the process undertaken in my search and review of literature on professionalism and professional identity in medical education. Then I review the literature on each of the two important concepts in the research question – professionalism and professional identity in medicine. As this study is an institutional ethnography of the medical curriculum, I then move on to review another important element in the research topic, the concept of curriculum in medical education, emphasizing the significance of different types of curricula in medical education. The last section is a summary and conclusion of the literature review, in which I summarize the progress and challenges in teaching/learning professionalism and developing professional identities, frame the relationship between the two objectives of medical education, and identify the research gap this study aims to fill. While this chapter highlights the literature on medical education and related issues, some of the relevant analytical literature will be introduced in the next two chapters of theoretical framework and methodology to situate the analysis and findings.

2.2 Literature search and review strategies

As this research project falls within the research area of sociology of medical education, and with medical education having its own scholarship and publications, it is essential to review literature in both sociology and medical education to provide a comprehensive understanding of the research topic. Therefore, I include, in this literature review, both the major work in the sociology of medical education and sociology of professions in general, and the more current knowledge of the practice of medical education. Besides reviewing the influential work in the past decades, a systematic literature search of professionalism and professional identity was also conducted to locate the most updated knowledge on the topic, especially in medical education literature. A combination of two search strategies was chosen to identify the relevant literature (Numerato, Salvatore, & Fattore, 2012).

First, a systematic literature search on professionalism and professional identity was conducted in both sociology (Sociological Abstract and SocINDEX) and medical education databases (PubMed, which includes access to database MEDLINE). The following keywords or combinations of keywords were selected in the title section for further analysis: medical professionalism, professionalism & medicine, professionalism & medical education, professionalism & medical students, professional identity & medicine, professional identity & physician, professional identity & doctor. As the number of articles was too large to review on PubMed, the time of publication was further limited to ‘in the last five years’. I screened the titles and abstracts resulting from the initial searches and excluded articles that focus on other health professions or do not address professionalism or professional identity. The strategy was highly effective in identifying relevant research in medical education literature. Second, a form of snowball sampling was used to identify articles and books that did not appear in the initial systematic
search but were commonly cited as significant to recent studies. This was a highly effective strategy in identifying sociological literature and supplementing the medical education literature. The identified relevant literature was reviewed in sequence to provide a comprehensive understanding of the three key concepts in the research topic – professionalism, professional identity, and curriculum (IE will be discussed in the methodology chapter). However, in the summary and conclusion section of this literature review, a connection is drawn between professionalism and professional identity. I also provide, in the summary and conclusion section, the current state of teaching/learning of professionalism and PIF in medical education through the lens of curriculum. A conclusion is provided to identify how this research could contribute to current literature.

2.3 Professionalism in medicine and medical education

Professionalism has traditionally been a cornerstone of the medical profession, subsequently becoming one of the most important discourses in medical education over the past two decades. In this section, I review the literature that examines professionalism in medicine and medical education. Firstly, I analyze the nature and function of professionalism in medicine. Being service- and altruism-oriented, medicine, as a profession that holds specialized knowledge and skills, and certain values, is tasked with a distinct role to care for the health needs of individuals and populations, and serves a unique purpose in the public sector. Professionalism, as one approach to organize and regulate medical practice, defines the contract between medicine and society.

Over the past decades, with changing social conditions and reforms, professionalism in medicine has become a more complicated social construct, which faces challenging forces from both within and outside of the medical profession. In the second section, I describe medicine’s professional crisis and its subsequent professionalism movement. Because of the increasing complexity of the concept of professionalism, how professionalism is defined and understood in medicine and medical education becomes more crucial as it directly impacts how medicine is and will be practiced, which will be the focus of the third section. This is followed by a review of the contexts that contribute to the changing definitions and understanding of professionalism, which are based on the disruption of the traditional professionalism and the call for a new professionalism. Lastly, I examine the current practice of teaching and learning on professionalism in medical education, highlighting the increasing attention to the dynamic nature of professionalism and the impact of context and learning environment.

2.3.1 The nature and function of professionalism in medicine

A profession, as an occupation that distinguishes certain kinds of people from others, is a dominant position in the division of labour and plays a significant role in the stable functioning of a society (Freidson, 1970). Gustafson (1982) identifies three criteria that distinguish professions from other work roles: 1) professionals use their discretion to apply a large body of knowledge to real-world situations; 2) to hold practice to high standards, professions are institutionalized and controlled and professionals are to form an identity with the professional
community; 3) professions are service oriented with the intention to address the needs of individuals and communities. The third criterion, according to Gustafson (1982), is the factor that makes professions a ‘calling’: “Not only subjective motives are involved, some vision of better lives for individuals, for groups, and even for the commonweal of the human community are part of a ‘calling’” (p. 511). Bellah, Madsen, Sullivan, Awidler, and Tipton (1985) distinguish the concept of calling from concepts of job, career and vocation, commenting that, “A calling links a person to the larger community, a whole in which the calling of each is a contribution to the good of all” (p. 66). The authors further acknowledge that as our society becomes more complicated and division of labour and specialization heightened, it is more difficult for a person to link his or her work to a broader scope of community (Bellah et al., 1985). Professions have traditionally developed a particularly distinct role in the public sector environment (Dent, 1993).

The analysis of the medical profession has a long history (Freidson, 1970). Doctors diagnose and treat sickness through acquiring a specialized body of knowledge and essential skills. Freidson (1970) argues that for doctors to be professionals, they also need to have an altruistic orientation towards the public they serve. Through individual commitment, together with a collective code of ethics, the profession of medicine defines itself (Carr-Saunders & Wilson, 1933). According to Parsons (1951), the commitment of doctors to patients serves as a desirable bridge that links two separate mechanisms in society: the rationality of market relationships in the public sphere and the affective relations in the private realm.

In discussing the function of professionalism in society, Wynia, Latham, Kao, Berg, and Emanuel (1999) comment that: “Professionalism is a structurally stabilizing, morally protective force in society. Along with private-sector and public or government activities, it is a cornerstone of a stable society” (p. 712). Sullivan (1995) dived into the very nature of professionalism and urged professions to move beyond a specialized self-interest and acquire a sense of social responsibility. Professionalism, as an activity, involves the distribution of a social good, which is uniquely defined according to moral relationships (Pellegrino & Relman, 1999). Professionalism, as an ideology of social reform, infuses social responsibility into the industrial division of labour (Sullivan, 2000). Freidson (2001) categorizes professionalism as the third logic in comparison to the two alternative logics of markets and bureaucracies in social organization of delivering goods and services.

According to Feld, Yeh, and Feld (2014), professionalism is also a well-established cornerstone of the practice of medicine:

> Whether defined in terms of a code of medical ethics, a set of core behaviours, or some loftier philosophical precepts, central to the idea of medical professionalism is the belief that the practice of medicine is a quintessentially public service. (p. 1587)

On how medicine could/should be organized and health care could/should be delivered, Wynia, Papadakis, Sullivan, and Hafferty (2014) comment that professionalism is only one of the approaches and not everyone believes in that, which means if professionalism fails to ensure trust and accountability, it could be revoked to substitutes, including consumerism and other ‘isms’ that depend less on public trust in medical profession and medical professionals. “The root
of the public’s trust is the confidence that physicians will put patients’ welfare ahead of all other considerations” (Sullivan, 2000, p. 675). The relationship of trust between practitioner and client is at the very heart of professionalism (Montague Jr., 1963). Professionalism, as the moral understanding among professionals, is a manifestation of the social contract between medicine and society. As Hafferty and Tilburt (2015) explain,

Professions, by definition, are allowed to regulate themselves, and do so on behalf of the others – the patients and society – they serve. In turn, this nominative mandate, reflective of medicine’s social contract with society, is supposed to be both individually internalized and collectively expressed in the form of altruistic practices. (p. 344)

Wynia et al. (1999) identify the three following elements for the model of professionalism in medicine: devotion to medical service; public profession of values; negotiation with the public regarding professional values and other social values.

2.3.2 Medicine’s professional crisis and modern-day professionalism movement

Increasing social diversity and complexity in recent decades have posed challenges to many traditional values and societal structures. All professions, including medicine, have seen their stature diminish (Cruess & Cruess, 2000). Because of the involvement of the private sector and intrusion of government into health care, medicine is losing both autonomy and influence around the world; Canada is no exception (Coburn, 1993).

Research in many countries, including research conducted by leading organizations and scholars, has revealed increasing commercialization of health care, which has been accompanied by a decline in physician accountability and trust of the public in the profession (Ho et al., 2014; Levey, 2015; Wang, Shih, Kuo, & Ho, 2016; Yoo, 2017; Zheng & Shi, 2016). There is an increasing public perception that the medical community puts more focus on protecting its own interests than serving the society and advancing broader public health goals (Blendon, Benson, & Hero, 2014). It is expected that what physicians do must focus on caring for patients, either directly or indirectly; however, as business is becoming much intertwined with the practice of medicine, it is becoming more difficult for physicians to remember to whom they have primary allegiance (DeAngelis, 2015). Nie et al. (2018) comment that as health institutions and health professionals become profit-driven, there exists a vicious circle in which patients and families distrust physicians and the health care system, which leads to physicians’ mistrust of their clients and defensiveness in practice, which leads to poorer health care outcomes and increasingly unsatisfied patients and families.

Another contributor to public discontent is the medical profession’s increasing focus on technical and scientific expertise, especially with the movement of evidence-based medicine, one of the consequences of which is the tighter alignment between technical expertise and physicians’ identity, in which the moral and social role of medicine is marginalized (Sullivan, 1999). Levey (2015) focuses on the public’s interest in delving into subjects of end-of-life care and dying well to raise the question of whether the medical profession is ready to meet patients’ and caregivers’ needs and desires, which is closely related to the future of public trust in physicians. Patients
across the world are experiencing new models of care and continuously expecting health care that is coordinated, responsive, transparent, efficient and personal. Related research also documents unprofessional conduct to be one of the many growing threats to professionalism (Kondro, 2002).

In conjunction with this professional crisis, the medical community has begun to examine current practice, promoting professionalism and professional behaviours as both a reaction and defence in response to public skepticism (Nie et al., 2018; Wang et al., 2016). Sullivan (2000) argues that for professions to have a future, professionals “need to make their case on the basis of a social and moral rather than a wholly technical understanding of what it is that professionals are about” (p. 675). This trend is termed “medicine’s modern-day professionalism movement” (Hafferty & Tilburt, 2015, p. 344). Hafferty (2003) comments that, in response to public skepticism, “organized medicine has sought respite and redemption by embracing the ideology of professionalism with an almost religious fervor” (p. 136).

Guidelines that address professionalism were subsequently created and endorsed by organized medicine. In 1994, the American Board of Internal Medicine (ABIM) commented in the Professionalism Project that “professionalism in medicine requires the physician to serve the interests of the patient above his or her self-interest” (p. 5) and identified three elements of professionalism required of candidates seeking certification from the ABIM:

A commitment to the highest standards of excellence in the practice of medicine and in the generation and dissemination of knowledge; A commitment to sustain the interests and welfare of patients; A commitment to be responsive to the health needs of society. (p. 5)

In late 1999, the European Federation of Internal Medicine, the American College of Physicians and American Society of Internal Medicine and ABIM launched the Medical Professionalism Project. In 2002, the Charter on Medical Professionalism – the principal product of the project – was published. The Charter identifies three fundamental principles of medical professionalism: “principle of primacy of patients’ welfare; principle of patients’ autonomy; and principle of social justice” (Medical Professionalism Project, 2002, p. 244) and a set of professional responsibilities. The Charter calls for physicians to reaffirm their active dedication to medical professionalism, which entails both their personal commitment to the welfare of their patients and their collective efforts to improve the health care system for the welfare of society (Medical Professionalism Project, 2002). The Accreditation Council for Graduate Medical Education (2000) also identifies professionalism as one of the six core competencies for graduate medical education.

The Royal College of Physicians in the UK also published a working report in 2005, Doctors in Society: Medical Professionalism in a Changing World, in a context in which the medical profession is facing unprecedented scrutiny. The report provides a definition of medical professionalism: “Medical professionalism signifies a set of values, behaviours and relationships that underpin the trust the public has in doctors”, together with a longer description of medical professionalism:

12
Medicine is a vocation in which a doctor’s knowledge, clinical skills and judgement are put in the service of protecting and restoring human well-being. This purpose is realized through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability. (Royal College of Physicians, 2005, p. 14)

The report further urges physicians to put patients at the heart of the new medical professionalism and focus on the partnership with patients and other disciplines (Royal College of Physicians, 2005).

Besides the official documents created by medical associations, we also witnessed a fast-growing literature on professionalism in medical journals, which is reviewed below in more detail. Within the ever-expanding literature in this field, researchers try to define the concept and develop a framework of the concept, call for a professionalism movement and urge practitioners to demonstrate professional behaviours to rebuild the public’s trust in medicine, and propose and evaluate innovative programs or modules or modify the overall curriculum to teach professionalism to the next generation of physicians. This has led Hafferty (2018) to conclude that medical professionalism, as a field of scholarship, is in search of its identity.

### 2.3.3 The definitional issue of professionalism

One common theme that emerges from the literature is defining and framing the concept of medical professionalism (Randall et al., 2016). Research revealed that having a proper theoretical knowledge of the concept is essential for building an effective relationship between the medical community and the patients it serves (Seif-Farshad, Bazmi, Amiri, Fattahi, & Kiani, 2016). This is also in part due to medical educators’ interest in identifying features of professionalism that can be expressed as measurable competencies and learning outcomes (Franco, Franco, Severo, & Ferreira, 2015). Some specialties also began to evaluate the aspects of medical professionalism that have particular relevance to their practice. For example, an exploration of emergency medicine residents’ perceptions of medical professionalism revealed that ‘respect for others’ and ‘honor and integrity’ were significantly valued more compared to the domain of altruism (Jauregui, Gatewood, Ilgen, Schaninger, & Strote, 2016).

According to Freidson (2001), “The most important problem for the future of professionalism is neither economic nor structural but cultural and ideological.” (Freidson, 2001, p. 213). There is increasing research that emphasizes local factors and cultural values that make the understanding of medical professionalism unique to a country or region, and examine the applicability of comparably established Western professionalism frameworks (Abdel-Razig, 2016; Hu, Yin, Bao, & Nie, 2014; Jotkowitz & Glick, 2015; Kim & Choi, 2015). For example, Ho et al. (2014) investigated the differences in medical professionalism between two Chinese cultural contexts and concluded that cultural values, social history and the structure of health care system all have a dynamic influence on the construction of medical professionalism in practice. The authors comment that global frameworks of professionalism need to be adapted to fit unique local contexts (Ho et al., 2014). In fact, the *Chinese Medical Doctor Declaration* – a Chinese version of
medical professionalism based on the *Charter of Medical Professionalism in the New Millennium* – added the longstanding Confucian and other cultural traditions of China, as well as the current social circumstances of medical practice in China (Jin, 2014). Respect is considered to be the most relevant component of professionalism in the Kenyan context and researchers urge medical schools in Kenya to incorporate it as part of the core curriculum of professionalism for cultural relevance (Ojuka, Olenja, Mwango’me, Yang, & Macleod, 2016). Nishigori, Harrison, Busari, and Dornan (2014) discuss the relevance of Bushido – a Japanese code of personal conduct – to medical professionalism in Japan and call for a richer discussion on the meaning of professionalism from the viewpoints of different cultures. Puschel et al. (2017) develop an original and culturally relevant definition of medical professionalism that is useful for medical school in Latin America. Klingler, Ismail, Marckmann, and Kuehlmeyer (2018) argue that support regarding professionalism and professional behaviours is needed for foreign-born and foreign-trained physicians.

Literature that emphasizes the impact of local and cultural contexts on the understanding of medical professionalism has led Jha, McLean, Gibbs, and Sandars (2015) to recognize that medical professionalism is a complex social construct. The authors also called for a conversation about global professionalism and a global approach to examine how professionalism is embedded in medical curricula. Al-Rumayyan et al. (2017) assert the need for current trainees to be future global practitioners who have the cultural sensitivity to recognize the variations in patients’ expectations in different contexts, which requires medical schools to take a culture-oriented approach to teach the concept of professionalism.

Wynia et al. (2014) argue that many recent definitions of professionalism in medicine focus on articulating a list of virtues, values and behaviours of professionals but do not explicitly address the foundational purpose of professionalism, which is to ensure that physicians are worthy of patient and public trust. This fundamental purpose recognizes the public’s key role in setting expectations and the role of physicians in the public sphere (Wynia et al., 2014). According to the authors, “The ‘list-based’ definitions of professionalism are quite functional for teaching, measurement, and certification, yet in several ways they also risk obscuring the foundational purpose, functions, and demands of professionalism” (Wynia et al., 2014, p. 713). Lee (2017) echoes this concern and discusses the significance of the definitional issue of professionalism: the lack of definition makes it a very flexible concept that could be applicable in a wide array of contexts; however, it also allows for the weaponization of professionalism, making it possible for professionals to leave out certain aspects of professionalism. Wynia et al. (2014) propose a new approach to viewing professionalism:

> At root, (professionalism) is the motivational force... Medical professionalism is a normative belief system about how best to organize and deliver health care. Believing in professionalism means accepting the premise that health professionals must come together to continually define, debate, declare, distribute and enforce the shared competency standards and ethical values that govern their work. (Wynia et al., 2014, p. 712)
Barnhoorn and Youngson (2014) observe that though dozens of definitions of professionalism have emerged and become longer, the patient has been moved further away from the center. Barnhoorn & Youngson (2014) wholeheartedly agree with the above statement on professionalism from Wynia et al. (2014) and ask physicians to place “the best interests of patients at the centre of everything” (p. 1579) they do. Almost two decades earlier, in the article Medical professionalism – Focusing on the real issues, Rothman (2000) had urged physicians to make professionalism more central to their thinking and behaviour and give up some of their self-interest for the benefit of patients’ and society’s interest. Rothman (2000) further commented:

A general call to embrace (professionalism) may be appealing and may even exert some influence in the long run, but it is not sufficient to bring about substantial change in the near future. Professionalism is too important for an exclusive reliance on such tactics. An infusion of strength and relevance is needed. By one means or another, professionalism must become a vital part of American medicine today. (p. 1286)

Hafferty (2018) comments that long before medicine’s professionalism movement, sociology has documented the influence of large-scale social changes “on medicine’s status as a profession and on the identity of physicians as professionals” (p. 532), which received little attention from the medical community. However, by the time that the profession of medicine began to recognize the “sociopolitical tremors and fault line, the analytic fervor within sociology had ironically begun to abate” (Hafferty, 2018, p. 532). According to Hafferty (2018):

This concomitant movement of awakening and abdication, however, did mark an important shift in the principal object of analytic concern – from Sociology’s long-standing focus on the profession as a collective entity to organized medicine’s emergent preoccupation with issues of professionalism, particularly at the level of individual practitioners and trainees (p. 532)

2.3.4 Changing definitions and understanding of professionalism

Though there has been disagreement on the relative importance of the different aspects of professionalism, one general consensus is that professionalism is made up of positively imbued characteristics (Goldstein & Donaldson, 1979). The norms of how medicine should be practiced, and therefore the definitions and characteristics of professionalism, change over time due to the evolving social contract between medicine and society, and the subsequent altered expectations of patients, society and physicians (Cruess et al, 2015; Cruess & Cruess, 2008).

Chronic diseases, most of which can only be managed but not cured, are becoming the leading causes of death and disability and impact an individual’s physical, psychological, vocational, and social endeavors (Nash, 2021). Providing quality care to patients living with chronic diseases requires more skills of physicians and increasingly depends on understanding the needs of patients and their subjective experiences with the disease to propose specialized treatment and care management approach (Jakobsen et al., 2021). On the broader social and cultural level, the rise of consumerism and consumers’ expectations for accountability, quality of care, and
transparency are powerfully influencing the image of the medical profession and what medical professionalism means (Cooke, Irby, & O’Brien, 2010). Another large-scale social development that impacts the delivery of health care is managerialism (Correia, 2013; Numerato et al., 2012; Tousijn, 2006). The worldwide reconfiguration of health care services, with the objective of enhancing the efficient and effective use of resources, has led many health professionals, including physicians, into performing hybrid management roles that require qualities of leadership, innovation, and life-long learning, besides simply providing patient care (Correia & Denis, 2016). This process is changing the organizational structures of physicians’ work and shaping their perceptions of their roles in society. The new information age also requires the reconfiguration of the medical professionalism (Rothman & Blumenthal, 2010). Some other structural changes that impact the development of professionalism and physicians’ professional identity are discussed later in relation to the changing dynamics in physicians’ professional identities.

The generational gap in the understanding of medical professionalism among physicians has been documented in the literature. For example, recent generations of physicians have distanced and continue to distance themselves from the lifestyle of physicians whose professionalism has been categorized as ‘nostalgic’ (Hafferty & Castellani, 2009; Tilburt & Sharp, 2016). They have committed to and continue to negotiate a new balance between lifestyle and work (Hafferty, 2003; Ross, Lai, Walton, Kirwan, & White, 2009). Lindheim, Nouri, Rabah, and Yaklic (2016) draw educators’ attention to the generational difference on professional standards, especially between Millennials, who are currently being educated and mentored, and the Baby Boomers and Generation Xers, who are the educators and mentors for the Millennials. There is a widely-held perception by older generation physicians of Millennial physicians that they are less devoted to the profession than others and see their physician role as a job but not their identity (Lindheim et al., 2016). However, other research suggests that Millennial residents take professionalism issues very seriously and have frequent concerns about situations they consider to be threats to professionalism (Krain & Lavelle, 2009).

To take into consideration the changing contexts of medical practice and changing expectations of health care, several new models of professionalism have been proposed in the literature. Kim (2019) makes a distinction between ‘classical professionalism’ and ‘professionalism in neoliberalism’, whose hallmark is commercialism that recognizes that doctors seek economic benefits. The author identifies two physicians’ approaches when encountered with this dichotomy: those who think commercialism threatens doctor’s classical virtues of altruism and compassion exclude commercialism from professionalism; and those who think classical professionalism is no longer realistic reject professionalism (Kim, 2019). The author, contending that neither approach is appropriate, suggests that physicians should consider and negotiate how they can play a professional role in the environment of health care that will continue to be influenced by commercialism, namely a feasible professionalism (Kim, 2019).

Growing research points to a web of commitments for physicians as professionals. Fenwick (2014) observes that: “Professionals must juggle obligations to institutional rules and efficiencies, to patients and families, to broad social needs, to medical science, to professional standards and
regulatory codes, and to their own personal values” (p. 1332). This has contributed to medical professionals making ‘legitimate compromises’, which involves navigating a path that simultaneously balances the need from different stakeholders without meeting the full expectation of any on the long list (Fenwick, 2014; May, 1996). Evetts (2011) studied the new realities of professionalism and documented that the ‘occupational professionalism’, through which a professional community self-regulates, is being displaced and overridden by ‘organizational professionalism’, in which employers’ demands and output measures are the priority. Tousijn (2006) proposes the ‘soft bureaucracy’ model, which includes sophisticated strategies and mechanisms that are not imposed but negotiated with professionals, and is presented as an opportunity to gain control over work and maintain the balance between professionalism and managerialism in health care work settings. However, research reveals a high level of variability in outcomes, which is made up of numerous sub-processes in health care production (Sheaff et al., 2003).

According to Tousijn (2006), with the ongoing concerns about health care, what is at stake is not just the individual doctor-patient relationship; it is the social contract between the medical profession and society. A new medical professionalism, which includes ideas for a new medical paradigm, multi-professionalism, and the relationship between different health care professions, is proposed to renew the social contract and respond to some of the challenges coming from social changes (Tousijn, 2006). Leadership discourse is strategically utilized and linked to positive institutional change in medicine (Berghout, Oldenhof, Fabbricotti, & Hilders, 2018). Physicians as leaders – opinion-making physicians – perform institutional work to advocate to reform medical professionalism (Berghout et al., 2018). Through “disrupting ‘old’ professional values and constructing the ‘modern’ physician”, the medical profession, as a body, could regain the lead in medical professionalism (Berghout et al., 2018, p. 68). The above changes in society and medicine, which not only pose challenges but also provide many venues for opportunities, “make today a very interesting time to be a physician” (Katz, 2014, p. 633).

2.3.5 Teaching and learning of professionalism in medical education

A large body of literature seeks to explore and evaluate new initiatives that teach professionalism in the medical curriculum. Shiozawa et al. (2016) developed a seminar on medical professionalism that accompanies the dissection course. The authors comment that medical professionalism is an underlying aspect of the dissection course and a teaching intervention is needed to explicitly discuss the topic (Shiozawa et al., 2016). Ward et al. (2017) used a custom-designed board game as an education intervention to imbue a culture of medical professionalism that is associated with patient safety. Hsieh, Kuo, and Wang (2019) report an initiative inviting students to share their observations of positive examples of professionalism with the support of social media and appreciative inquiry. Foucault, Dubé, Fernandez, Gagnon, and Charlin (2015) discuss the application of the Concordance of Judgment Learning Tool, which is comprised of 20 vignettes involving professionalism issues and is complemented by feedback and explanation from attending physicians, in teaching medical professionalism. Students’ engagement with the medical humanities in the curriculum can facilitate their understanding of and appreciation for the social and ethical dimensions of medical professionalism, which is essential to provide
patient-centred care and reclaim the art of medicine (Charon, 2001). Shapiro, Nixon, Wear and Doukas (2015) suggest using literature to engage learners in questioning conventional thinking and assumptions about the different dimensions of professionalism, which can be more effective than students reading a manual on professionalism from a certain organization.

Most of the research on evaluating the impact of pedagogy on students’ understanding of professionalism has been shown to have a positive impact on fostering the development of professionalism (Foucault et al., 2015; Hsieh et al., 2019; Shiozawa, 2016). However, it is important to note that most of these evaluations use surveys as the dominant method to investigate the impact on students’ understanding of one very specific aspect of professionalism and the impact is assessed in relation to understanding instead of internalizing or performing. According to Chen, Xu, Zhang, & Fu (2013), physicians’ behaviours can be, at times, inconsistent with their attitudes. Research is also done on how best to assess medical professionalism with various instruments developed and utilized (Kwan et al., 2018; Li, Ding, Zhang, Liu, & Wen, 2017). Li et al. (2017) have found that even though these instruments show diversity in tools and target population, there is also variation in the performance of measurement properties and methodological quality of research studies that utilized these tools. There is need for comparative and longitudinal studies (Li et al., 2017).

There is consensus among medical students that there are areas for improvement in medical schools’ current approaches in teaching medical professionalism (Sternszus, 2016). Joiner, Husain, Duddu, and Chaudhry (2015) reveal a lack of formal teaching and adequate educational opportunities. Twenty-five percent of the psychiatry trainees they surveyed indicated that they had some sort of formal training and 78 percent felt that teaching was not adequate. Another big concern from the findings of this study was that nearly 20 percent of the trainees did not consider their supervisors to be good role models of professionalism (Joiner et al., 2015). Students also viewed some of the formal teaching as ‘tick-boxing’ and thought their learning needs and expectations were not met, which further led students to believe those courses on professionalism were irrelevant to their training to be physicians (Stockley & Forbes, 2014). Stockley and Forbes (2014) suggest that some students might prefer the apprenticeship model of medical education, in which experience and wisdom are conveyed opportunistically instead of tutorials and checklists, especially on topics like professionalism. This study also emphasized that the ‘buy in’ from learners and faculty is imperative to the success of curriculum change (Stockley & Forbes, 2014).

Medical students claimed that their preceptors were more likely to evaluate students’ appearance, formality, and conformity as professional than students’ traits of honour, altruism and responsibility, which are aspects that take much longer to observe and give feedback on (Brainard & Brislen, 2007). Students also felt that the training on professionalism in medical school was patronizing and demeaning (Baernstein, Oelschlager, Chang, & Wenrich, 2009) and saw it as little more than a tool of governance and regulation employed by medical school (Petersen, Bleakley, Brömer, & Marshall, 2008). According to Heffner (2016), “Call for professionalism has become as much an administrative mandate as an aspirational goal” (p. 293). In discussing the relevance of medical ethics to medical professionalism, Dunn (2016) urges that
medical professionalism should not be interpreted in terms of compliance – exposing students to knowledge about ethical duties or guidelines that apply to their practice – but needs to be fostered in settings that are socially and institutionally diverse.

Janczukowicz and Rees’s (2017) article is one of the exceptions that acknowledge the different dimensions of how professionalism is used in medical education literature, explicitly distinguishing between academic professionalism (AP) and medical professionalism (MP). The findings reveal that while the common themes in AP were learning, lifestyle and personality, the attributes of MP were knowledge, ethics and patient-doctor relations (Janczukowicz & Rees, 2017). Perhaps a more significant finding from the study was the students’ struggle to articulate the relationship between AP and MP, which were seen by them as two separate constructs (Janczukowicz & Rees, 2017). What medical students are exposed to in their learning environment can lead them to employ different discourses when considering professionalism: some focus on how they act or appear while others have more complex and deep-valued understanding of professionalism (Monrouxe, Rees, & Hu, 2011). This has led to a phenomenon in which researchers use alternative concepts, such as ‘true medical professionalism’ (Yoo, 2017), to define the scope of their research.

This definitional issue of professionalism, which was also discussed in the literature review, has immediate relevance to the teaching and learning of professionalism in medical education. Hafferty (2018) and other researchers (Hafferty & Tilburt, 2016) have observed that the ways in which a community defines or frames an issue can exert significant influence on how members in the community view and respond to the issue – in this case the issue being professionalism. In other words, definition can shape evaluation and resolution (Hafferty, 2018). The way the medical community and medical schools define the concept of professionalism impacts what and how students learn on professionalism issues. Medical students’ view of professionalism is a reflection of the immediate context of their educational environment, in other words, their training and experiences (Randall et al., 2016).

According to Hafferty (2018):

If professionalism is defined as residing in the behaviours and motives of individual physicians and trainees, then solutions to that problem are similarly constrained. But, what if the problem is not one of motives? What if the answers to issues of professionalism are not to be found (exclusively) in more course work, more frequent assessment, or more strictly enforced codes? (p. 533)

Hafferty (2018) urges the medical community to be more proactive in reviewing the contexts and settings in which medical practice and medical education operate. Tilburt and Sharp (2016) comment that the medical community needs to take a holistic approach to understand the many threats to medical professionalism and re-envision a system or model that cultivates a robust culture of caring.

Levinson et al. (2014) reject the idea that professionalism is a static character trait that a medical trainee or physician either has or does not have and instead argue that it is a series of behaviours,
skills and values that can and should be taught and practiced throughout one’s training and career. According to O’Gara, Ness, and Harold (2015), learning and improvement on professionalism should be a continual community effort, which requires a culture that supports the ability of team members who encounter professionalism challenges in daily practice. Similarly, Hafferty (2018) suggests that:

Perhaps professionalism is more of a journey than a destination. Perhaps professionalism is best captured not in a definition or metric but in the willingness of a community to engage with itself in an ongoing and reflective search for a soul defined by the core values of selflessness and service? Perhaps the true promise of medical professionalism lies not in professional dominance or in the metrics of accountability but in the willingness of a community to do its best, patient by patient, and to do so even in the face of the increasing social divisiveness that today seems to dominate so many specters of social life. (p. 535)

Professionalism holds a unique position in the establishment and development of the medical profession, and now increasingly in medical education. The context within which the health care service is provided continues to challenge clients’ and professionals’ understanding of medical professionalism. While the teaching of professionalism is somehow established, at least in educational guidelines and organizational documents, another related learning objective of medical education, namely PIF, is starting to receive more attention from medical educators and medical education literature, which is the focus of the next section in this literature review.

2.4 Professional identity in medicine and PIF in medical education

The professionalism movement has resulted in an important shift in understanding the focus of medical education. The acquisition of knowledge and skills is only one step in the larger process of trainees’ gradual induction into the community of medical practice. An equally important goal of medical education is educating trainees to identify with the purposes and values of the medical profession, and physician roles that are defined by medicine’s contract with society. These elements together support trainees to develop a professional identity. In this section, I provide a literature review of professional identity in medicine, with an emphasis on PIF in medical education. I start by establishing the importance of professional identity in medicine. A clear sense of one’s professional identity allows physicians to know their place in society and in the medical profession. Because of this, supporting medical trainees to form an identity that integrates their professional and personal identities and could sustain their professional career has become a focus of medical education.

In the second section, I move on to describe the process and mechanisms of PIF. PIF is a dynamic, longitudinal, and interactional process and depends heavily on observation, role modelling, relationships, experiential learning, and continuous negotiations that are based on experiences and changing learning and working contexts. This is followed by a discussion on the changing dynamics in professional identity in medicine. The advocacy for interprofessional practice, marketization and consumerism in health care, technological advancement, and the popularity
of social media continue to require physicians to negotiate their professional identity in a rapidly changing world. The last topic in this section is a review of current practices in medical education that facilitate the formation of professional identity, among which I highlight the potential of reflection, mentorship, early encounter with patients, and innovative clerkship models.

2.4.1 Importance of professional identity in medicine

Cruess et al. (2014) define a physician’s identity as a “representation of self, achieved in stages over time during which the characteristics, values, and norms of the medical profession are internalized” (p. 1447). A person needs three levels of identity to be who he/she is – personal identity, role identity and group identity (Owens, Robinson, & Smith-Lovin, 2010). All social groups must navigate and balance the tensions between internal integration and external adaptation (Schein, 2004). According to Beaulieu et al. (2008), “the question of professional identity is not insignificant” (p. 1154). Abbott (1988) explains that professionals need a clear sense of their chosen profession’s identity and area of expertise to function and collaborate with other professions effectively.

Novelskaitė and Riska (2006) observe that in the early sociological study of professions, professions were perceived as “a united body of like-minded individuals, who share a common view and have shared professional interests” (p. 47). It was taken for granted that there existed “professional unity and a shared professional identity” (Novelskaitė & Riska, 2006, p. 47). This was evident in some classic sociological work on professions (Abbott, 1988; Freidson, 1970; Larson, 1977; Parsons, 1951). However, later work explores professional diversity (Evetts, 1999; Freidson, 1984,1985; Leicht & Fennel, 2001; Zetka, 2003). Evetts (1999) observes that there were diverse groups of specialists in most professions and urges researchers to pay more attention to “within-profession diversification” (p. 15). Zetka (2003) argues that, similar to the competition and negotiations between professions, subgroups within a profession negotiate clear work jurisdictions and distinct professional identities.

Because of the broad scope of the practice of medicine, a large body of literature focuses on the professional identity of physicians in a specific specialty (Cope, Bezemer, Mavroveli, & Kneebone, 2017). For example, surgical residents identified that some of the learning necessary for a surgical professional identity included “learning to be a perfectionist, to be accountable, and to self-manage and be resilient” (Cope et al., 2017, p. 544). Literature on the specialty of family medicine has documented medical students’ diminishing interest in primary care as their career choice (Bowler & Jackson, 2002; Rosser, 2002; Sox, 2003). Due to this, combined with practitioners’ desires for reduced working hours, some OECD countries, including Canada, are experiencing a relative shortage of primary care physicians (Simoens & Hurst, 2006). An increasing percentage of general practitioners are restricting their practice, which limits people’s access to primary care providers, especially in rural and remote regions (National Physician Survey, 2007). PIF is critical to the practice of exemplary medicine and the well-being of both patients and physicians (Holden et al., 2015).
The title of the first edition of the book on teaching professionalism in medical school by Cruess, Cruess, and Steinert (2009) was simply *Teaching medical professionalism*; however, the title of the second edition of the book was changed to *Teaching medical professionalism: supporting the development of a professional identity* (Cruess, Cruess, & Steinert, 2016). This change highlighted the transition of teaching and learning medical professionalism from an outcome to a process with the end goal being the development of professional identities among medical students. One of the four goals recommended for medical education from a 2010 report – *Educating physicians: A call for reform of medical school and residency*, sponsored by the Carnegie Foundation for the Advancement of Teaching – is the “focus on professional identity formation” (Cooke et al., 2010, p. 6). This goal is listed as equally important to the other three recommended goals: “standardization of learning outcomes and individualization of the learning process; integration of formal knowledge and clinical experience; development of habits of inquiry and innovation” (Cooke et al, 2010, p. 5-6).

Medical students go through personal and professional changes that can be transformative during medical training (Green, 2015). A united professional identity, through shared values, can bring together a diverse group of trainees, who have various personal identities shaped by their cultural upbringing (Sawatsky, Beckman, & Hafferty, 2017). According to Kumar (2018), a strong sense of shared social identity (for example, medical students or health care professionals) is beneficial for combating the increasing rates of anxiety and depression among physicians and physicians-in-training. However, there exist differences in the individual conceptualization and development of professional identity (Cruess & Cruess, 2016). Research has shown that diversity in medical students’ cohorts can contribute to enhancing the learning experiences for all learners and producing more physicians who are culturally competent and better prepared to serve a heterogeneous patient population (Cooke et al., 2010). For example, Stergiopoulos, Fernando, and Martimianakis (2018) explore the experiences of medical students with disabilities. The student experiences as patients and as trainees led to excellence in communication, advocacy, and compassion, which highlights the potential of enhancing students’ personal identity to build professional identity (Stergiopoulos et al., 2018).

Researchers are also advocating for a context-specific approach to PIF and broadening the discourse on professional identity to include approaches and notions that are non-Western (Helmich, Yeh, Kalet, & Al-Eraky, 2017) to not reproduce or preserve the status quo of a historically white and male medical culture (Matsui, Sato, Kato, & Nishigori, 2019; Volpe, Hopkins, Haidet, Wolpaw, & Adams, 2019). Medical schools, to embrace the mandate of social accountability, are increasingly accepting medical students from diverse backgrounds so they can better serve the diverse patient populations (Razack, Hodges, Steinert, & Maguire, 2015). However, medical students’ reflections revealed that when these diverse medical students entered medical training, they were immediately met with the pressures, which occurred at both formal and informal levels, to conform to a pre-set professional identity (Frost & Regehr, 2013). In the article “Medical students are not blank slates: Positionality and curriculum interact to develop professional identity”, the authors, who are medical students, urge the medical community to recognize the value of their lived experiences before medicine, which have been
influential in their trajectory into medicine (Fergus, Teale, Sivapragasam, Mesina, & Stergiopoulos, 2018). The authors further comment:

Empowering students to integrate their pre-medical backgrounds into their developing identity is crucial not only to improving the process of professional identity formation for diverse students, but also to nurturing empathic and insightful physicians uniquely suited to respond to the plights of their patients. (Fergus et al., 2018, p. 6)

A cultural system and work environment should be developed to cultivate a professional vision that welcomes a wide variety of professional and personal identities, and pathways through which the two identities can be integrated (Matsui et al., 2019).

Medical trainees and physicians not only need a professional identity, they also should have a sustainable professional identity. In other words, professional identity is a critical factor in determining career sustainability, which requires clinician resilience and enhanced well-being (Rosenblum, Kluijtmans, & ten Cate, 2016; Wald, 2015; Wald et al., 2015). Medical students need mentors, and physicians need colleagues to work through any clinical or non-clinical experiences that challenge their professional identity (Weissman, 2015). Reflecting on the gap between patients’ and institutions’ expectations for physicians, Hafferty, Michalec, Martimianakis, and Tiburt (2016) ask the following question:

(Is) PIF might be just another way to ‘on board’ learners as managerial functionaries in the service of an increasingly formative and (formidable) biomedical-industrial complex, or whether the construction/formation of physicians-qua-professionals is about cultivating a future practice community whose collective moral vision, character, and potentially disruptive advocacy on behalf of patients may come to subvert the very structures and processes that initially gave rise to that identity. (p. 171)

Medical educators should, besides socializing trainees into a professional group identity, allow and support trainees to build the capacity to resist applying bureaucratic and standardized solutions to contemporary health care problems (Hafferty et al., 2016).

### 2.4.2 PIF in medicine

PIF is defined as the “development of professional values, actions, and aspiration”, and “should build on an essential foundation of clinical competence, communication and interpersonal skills, and ethical and legal understanding, and extend to aspirational goals in performance excellence, accountability, humanism, and altruism” (Cooke et al., 2010, p. 6). Bebeau (2006) also describes the process of PIF:

Individuals move from self-centered conceptions of identity through a number of transitions, to a moral identity characterized by the expectations of a profession – to put the interests of others before the self, or to subvert one’s own ambitions to the service of society. (p. 65)
PIF is a dynamic process made possible through socialization, which was the principal interest in the first two major works in the sociology of medical education (Becker, Geer, Hughes, & Strauss, 1961; Brosnan, 2009; Merton, Reader, & Kendall, 1957). In the book *The Student-Physician*, Merton et al (1957) describe the socialization of medical students as:

> the process through which he(she) develops his(her) professional self, with its characteristic values, attitudes, knowledge, and skills, fusing these into a more or less consistent set of dispositions which govern his(her) behavior in a wide variety of professional situations. (p. 287)

This socialization process, during which medical students are gradually assimilated into the world of medicine, is central to not only the development of individual medical students, but also the maintenance of the medical education system, which contributes to institutional stability (Brosnan, 2009; Gao, 2015; Hafferty & Castellani, 2009). Another major work – *Boys in White* – focuses on medical students’ daily experiences and the strategies they adopt to survive medical school instead of institutional stability (Becker et al., 1961; Bloom, 1965).

Every medical student’s journey of PIF – from a layperson to a skilled professional – can be different. There are diverse structural and personal forces that are at play (Sharpless et al., 2015). The journey is a combination of who the students are before medicine and who they aspire to be through the process of medical training, which is affected by their experiences in medical school with peers, faculty, patients, staff, and families and friends (Cruess, Cruess, Boudreau, Snell, & Steinert, 2015). Medical trainees’ roles in and responses to the socialization process play a part in the final outcome of PIF. The response of each individual to simulation and to the socialization process varies, but they all go through a series of personal negotiations as they acquire the new identity (Cruess et al., 2015). When and how they alter their existing identities, and take on the new identities, differs; some students navigate the process with little difficulty while others can struggle with it (Cruess et al., 2015). However, repressing one’s existing identity to some degree is frequently required, which can lead to ‘identity dissonance’ because of the conflict between one’s new identity and the old identity, with the results being students either rejecting the new identities or making a compromise between the new and old identities (Cruess et al., 2015; Erikson, 1982; Monrouxie, 2010).

In pre-med education, personal activities that students undertake are often considered distinct from their academic identities; however, entering the medical profession, students must immediately assume and perform a professional identity, where personal activities can become relevant in a professional context (Ross et al., 2009). Jowsey (2018) comments on the blurry boundaries of personal self and professional self, which means that professionalism can move beyond the body and the immediate practicing and learning environment, and be present in abstract spaces, such as the Internet. Jowsey (2018) concludes that the discourse of professionalism indicates that there is no separation of personal self from professional self, which, for medical students, means the self continues to be in a process of becoming a professional.

It is common for students to enter medical school with only a superficial knowledge of the values that underpin the practice of medicine and how the values inform the expectations of them...
throughout the educational process. Medical students have his/her own ‘figured world’ entering medical school, shaped by personal experiences and assumptions transmitted by others (Kumar, 2018). According to Cooke et al. (2010), “one of the major ways of promoting professional formation is to immerse trainees in a setting that embodies the highest values of the profession – excellence, collaboration, respect, and compassion” (p. 6). Six domains of professional identity identified by Holden et al. (2015) are: attitudes, personal characteristics, duties and responsibilities, habits, relationships, and perception and recognition, which focus on not only learning and acquisition, but transformation of medical students. Kay, Berry and Coles (2019) identify the following four experiences as triggers to professional identity development: “transition from undergraduate student to medical student; clinical experiences in the preclinical years; exposure to the business of medicine; and exposure to physicians in clinical practice” (p. 17). Using conceptual change theory, Kay et al. (2019) document how these experiences, which cause cognitive conflict or cognitive disequilibrium, challenge “medical students’ self-perceptions, or naïve theories of self-in-profession” (p. 18).

The learning of attitudes, values and behaviours – professional identity construction – occurs through close observation and role modelling (Cope et al., 2017). Lave and Wenger (1991) conceptualize that learning in apprenticeship occurs through ‘legitimate peripheral participation’ and change in identity is one of the markers of apprenticeship-style learning. The decline of the apprenticeship model in medical education, which leads to diminished contact between trainees and their trainers, could have unintended consequences for professional learning and the development of professional identity (Cope et al., 2017). Bandura (1977) notes that even though learning through close observation could lead to changes in behaviours, sustained change has to come from external and internal motivations of trainees.

Relationship plays a key role in PIF (Sharpless et al., 2015). Within the complex learning environments, students actively construct their professional identities through interactions with peers, mentors and patients (Wong & Trollope-Kumar, 2014). Societal expectation is also shown to influence students’ understanding of their professional roles and identities. Students’ reflections demonstrate that they are aware of the dramatic changes in the ways others perceive and treat them, which makes them wonder whether they are competent to handle the responsibilities and expectations (Wong & Trollope-Kumar, 2014). Simulated patients, who are lay individuals that often encounter students longitudinally, can offer a unique lens to understand medical students’ emerging identities as future physicians. They identify being older, being exposed to real patients and having previous health care experience as factors contributing to medical students developing an identity of physicians, and recognize that, for some students, the existing identity might impede the development of a professional identity (McLean, Johnson, Sargeant, & Green, 2015).

Research also links experiential learning, service learning and transformative learning, which put the interactions between learners, experiences, and the mentorship of role models at the centre, to PIF (Beck, Chretien, & Kind, 2015; Sajisevi, Wilken, & Lee, 2016; Sawatsky, Nordhues, Merry, Bashir, & Hafferty, 2018). Lectures and case studies cannot capture the patients’ real experiences of illness and are not emotionally engaging for students (Weaver et al., 2014). PIF requires
personally significant learning and personal transformation that is grounded in emotional experience and possible mostly through experiential learning and service learning that could lead to transformation (Dirkx, 2008; McNaughton, 2013). Sawatsky et al. (2018) examine international health electives for residents and identify “disorienting experience; emotional response; critical reflection; perspective change; and a commitment to future action” (p. 1381) as five key components of transformative learning.

The construction of professional identity is ongoing work, even for practicing physicians. They continue to negotiate their professional identities in the workplace. Allsop and Mulcahy (1998) draw on the concept of identity and investigate how physicians maintain professional identities when confronted with patients’ or carers’ complaints. Complaints can be interpreted as a challenge to physicians’ technical competence and a loss of trust in them, which lead to physicians’ experiences of a loss of control that require identity work to fix (Allsop & Mulcahy, 1998). Through giving explanations and excuses, such as the limitations of biomedicine or the risks of particular specialties, physicians justify themselves as competent and protect their professional identity, which is separated from the concerns of the complainant (Allsop & Mulcahy, 1998). The authors argue that this collective reaction contributes to professional politics, in which people in medicine share ways of thinking and explaining, and reinforcing collective understandings about the practice of medicine as opposed to that of lay people or managers (Allsop & Mulcahy, 1998).

In the article “I deal with the small things”, Johansen, Holtedahl, Davidsen, and Rudebeck (2012) use general practitioners’ experiences of caring for cancer patients and their interpretation of their practice “as a search for a trusting relationship to the patient and for a professional identity within the existential situation of shared humanness” to explore “two coexisting perspectives of medicine: medicine as the science of biomedicine or medicine as a clinical practice of moral and relational origin, which uses biomedicine as a tool” (p. 570). General practitioners deal with many existential and social aspects of general practice—the life world of patients (Johansen et al., 2012). This strong loyalty and commitment can be in conflict with the demands of the health care system and the judgment of hospital colleagues (Johansen et al., 2012). According to Rosser & Maguire (1982), the dominant biomedical perspective on cancer care led to general practitioners’ subordinate status. The same domination of medical model in medical education makes it difficult for physicians to fully understand the importance of other roles that physicians fulfill in caring for patients after they have graduated and they must experience it and learn through their practice (Johansen et al., 2012).

2.4.3 Changing dynamics in physicians’ professional identity

The current advocacy for interprofessional practice has forced physicians to reconsider their professional identity in working closely with other health professionals. Professionals struggle with who they are in relation to many relevant constituencies (Netting & Williams, 1996). In a rapidly changing health care environment, boundaries between professional jurisdictions are always subject to continued negotiation and renegotiation (Beaulieu et al., 2008). The changing social and health needs, and the subsequent reorganization of health care systems require
redefinition of the professional identities and practice scopes of health professions. Medicine is no exception. Interprofessional education, in which trainees from different health professions get together and work collaboratively on health-related cases, is a model being invested in medical education (D’Eon, 2005). When compared and contrasted with the roles of other health professionals, interprofessional interactions could potentially illuminate medical students’ understanding of the physician role (Sharpless et al., 2015). However, according to Netting & Williams (1996), “Collaborations are being forced on those who have been socialized to believe that they must be unique to prove their worth and demonstrate their professional identity” (p. 218). Ross (1994) explains that for current health professions trainees and future practitioners to survive in the environment of contemporary health care, it is essential that educators in different health professions break down institutional barriers that are embedded in entrenched university systems to truly collaborate and model relevant behaviours and skills for their students.

Other reforms within the health care system also impact physicians’ professional identity. Research has documented that marketization and consumerism in health care are causing physicians to have conflicted professional identity. The traditional physician-patient relationship, built on implicit trust, is gradually being replaced by a relationship characterized by mistrust, self-interest and opportunism (Nie et al., 2018; Tang & Guan, 2018). Bertin & Pantalone (2019) reveal that the move of the centre of the health care system from the hospital to primary and community care challenges not only organizational processes with planning and operation but also professional culture and identity. The authors document the possible unwillingness of specialist physicians “in the transition from operational practices centred on the mere achievement of the result – where the focus is on the doctor-patient relationship – to more complex work practices, which must integrate different actors in a shared operational plan” (Bertin & Pantalone, 2019, p. 27). According to the authors, such unwillingness:

confirm(s) the difficulties of balancing the professional culture with the organizational dimension, in particular in the transition from a logic closed to the free market (where the doctor has greater independence) to a bureaucratic and hierarchical one (where negotiation and teamwork are fundamental). (Bertin & Pantalone, 2019, p. 27)

This transition requires not only adding more items to the competency framework for physicians, but also conversations and discussion through which physicians can negotiate and identify with their changing role instead of being forced to demonstrate the ideal profile of physicians who ‘can do it all’. Spehar, Frich and Kjekshus (2015), documenting physicians’ experiences of struggles in reconciling the role as health professional and the role as clinical managers, urge health care organizations to consider identity and need satisfaction when recruiting clinical managers.

The development of technology and popularity of social media also have potential for changes in physicians’ professional identity. McKenzie & Williamson (2016) reveal a new generalist primary care identity as innovators in telehealth with the emergence and popularity of telephone triage and advice services in western health care systems. These general practitioners, in collectively re-aligning their practice to fit the helpline role, have identified a new form of generalist (McKenzie & Williamson, 2016). Social networking sites, being widely accessible and
comprehensive, further blur the line between what is considered personal and what can have an influence on the public’s perception of the medical profession (Ross et al., 2009). Gorrindo & Groves (2008) found that patients increasingly search for information about their physicians over the Internet. Furthermore, their perception of the professionalism level, or even competence, of the physician taking care of them could be adversely affected by discovering inappropriate or questionable content either posted by or about their physician (Collier, 2012). Research also reveals that personal profiles that contained healthy behaviours were regarded as most professional, followed by profiles that contained strictly professional content (Clyde, Rodríguez, & Geiser, 2014). These phenomena have contributed to medical schools regulating students’ behaviours on social media and resulted in frustration and resistance from medical trainees, who demonstrated a fierce protection of their private time outside of medical school (Ross et al., 2009).

There is growing literature on the interaction between the practice and training of medicine, and social media. Social media provides a venue to easily share health information globally and permanently, however, with unclear risks and benefits (Katz, 2014; O’Regan, Smithson, & Spain, 2018). Fenwick (2014) argues that even though there is emerging literature that suggests the potential of social media to enhance medical practice, most of the literature voices concerns about its perceived abuses. In response to such worries, many organizations have made explicit regulations about social media use (General Medical Council, 2012; Kind, Genrich, Sodhi, & Chretien, 2010; Rouprêt et al., 2014) and some have argued for ‘e-professionalism’ as a new paradigm that includes certain training and expectations (Al-Eraky, 2015; Cain & Romanelli, 2009; O’Regan et al., 2018; Spector et al., 2010). According to Fenwick (2014), medical educators need to understand more closely and deeply how social media affects the boundaries of professional work and professionals’ online identities instead of utilizing the simplistic good/evil framing in professional training. Cunningham (2014) argues that if we are to acknowledge that becoming a professional and constructing a professional identity is indeed a complex and interpersonal activity, the guidance on social media and professionalism should reflect this complexity. It is probably no longer feasible for physicians, as Schuklenk (2006) argues, “to leave the non-professional aspects of personal life at the door and face patients as medical professionals and no more” (p. 1).

2.4.4 Facilitating PIF in medical education

Even though professional identity is a much newer concept, compared to professionalism in medical education, research on how best to facilitate medical trainees’ PIF has already started to emerge.

Reflection is identified to be one of the main approaches to facilitate PIF although there are different forms utilized, for example: tutored reflection (Morgan, Moore & Duff, 2019), guided reflection (Sharpless et al., 2015; Wald, White, Reis, Esquibel, & Anthony, 2019), highly humanistic formation narratives (Branch Jr & Frankel, 2016), narrative reflections (Wong & Trollope-Kumar, 2014), narrative medicine (Miller, Balmer, Hermann, Graham, & Charon, 2014), and interactive reflective writing (Wald et al., 2015). According to Wald et al. (2019), interactive
reflective writing, which in their study is specific to clerkship, supports students to grapple with the lived reality of medicine and make meaning of complex experiences in a safe learning environment. Miller et al. (2014) argue that “narrative medicine seminars support complex interior, interpersonal, perceptual, and expressive capacities” (p. 335). Discussing the role of physicians, Charon (2001) comments:

A scientifically competent medicine alone cannot help a patient grapple with the loss of health or find meaning in suffering. Along with scientific ability, physicians need to listen to the narratives of the patient, grasp and honor their meanings, and be moved to act on the patient’s behalf. This is narrative competence, that is, the competence that human beings use to absorb, interpret and respond to stories. (p. 1897)

Mentorship is a crucial link between critical reflection and PIF and can make possible true transformative learning (Cruess et al., 2015). PIF is also facilitated by feedback provided by faculty and how it is received and incorporated by students. Coaching groups, which provide a safe environment to share thoughts and feelings, are shown to be effective for junior doctors, who are going through the transition from medical school to working life, to respond to everyday challenges (De Lasson, Just, Stegeager, & Malling, 2016). De Grasset et al. (2018) reveal that medical students’ participation as actors in Objective Structured Teaching Exercise made them more comfortable viewing their medical school as a learning environment where errors could be opportunities for learning, and better prepared to receive faculty feedback. Morgan et al. (2019) emphasize the importance of open and non-judgmental mentorship along with opportunities for medical students’ reflection in supporting the transition from medical student to doctor. Medical students suggest that tailored mentorship programs that match trainees to role models who share similar lived experiences make it possible for them to be empowered and embrace their unique experiences (Fergus et al., 2018).

Patient encounter is one of the central learning opportunities for medical students’ PIF (Brandt, 2017; Wong & Trollope-Kumar, 2014). Patient-partnership, which offers a disruption to the traditional lines of construction of professional identity in preclinical years of training, has been used in medical education to facilitate a patient-centred professional identity (Barr, Bull & Rooney, 2015). Barr et al. (2015) argue that patient-centred practice should be encountered by students at an early stage of their socialization process, with a need for ongoing engagement with patients throughout medical education (Barr et al., 2015).

Research also investigates the impact of innovative clerkship models on medical students’ PIF. The longitudinal integrated clerkship (LIC) supports educational continuity and enhances students’ connections to patients and faculty role models, which better serve the developmental needs of medical trainees (Gaufberg, Shtasel, Hirsh, Ogur & Bor, 2008; Hirsh, Ogur, Thibault, & Cox, 2007). Graduates of the Harvard Medical School’s Cambridge Integrated Clerkship (CIC), which is one example of LIC, identified the following elements to be fundamental to their PIF: “encouragement to integrate pre-professional and professional identities; support for learner autonomy in discovering meaningful roles and responsibilities; learning through caring
relationship; and a curriculum and an institutional culture that make values explicit” (Gaufberg et al., 2017, p. 258).

Other innovative or programs are also explored and evaluated in the literature. One program invites medical students to create comics as a way to reflect on the meaning of their experiences. As a formative activity, it contributes to students’ PIF (Green, 2015). Reis and Wald (2015) describe an innovative module, The Holocaust and Medicine, in medical curriculum, which promotes humanistic and ethically responsible practice and medical students’ identities as future healers. Kalet et al. (2017) argue that PIF should be measured early in medical school to establish a baseline, which can be used to support individual professional development and monitor progress through medical training. According to Korkmaz and Senol (2014), longitudinal and formative assessment is essential for PIF. One example is the professional development e-portfolio, which allows students to document the changes in their personal beliefs of the medical profession (Holden et al., 2015; Wald et al., 2015; Wong & Trollope-Kumar, 2014). Tagawa (2019), describing one attempt to evaluate medical PIF with a development scale, reveals that experience in playing the role of physician could facilitate medical trainees’ PIF.

Professional identity is closely linked to professionalism, not only in organizational guidelines but also in medical education research (the relationship between the two is reviewed later). Though newly embraced by the medical community, professional identity serves the function of more than just another learning objective of medical education. The concept and the theoretical frameworks utilized to understand its importance and the formation of it draw researchers’ and medical educators’ attention to the dimensions of medical training that are outside the formal curriculum. It is evident from the discussion on teaching and learning of professionalism and facilitating PIF that formal teaching on those two subjects is only one channel through which students learn professionalism and develop professional identity. Curriculum reform in medical education is addressing not only course work but also informal ways of learning such as observation, role modelling, mentorship and interactions with patients, and the more structural level of impact such as learning environment and institutional culture. The following section investigates another key concept in the research question – curriculum – and explains why the different dimensions of curriculum in medical school are particularly relevant to these two learning objectives of medical education.

### 2.5 The concept of curriculum in medical education

Education, more than just teaching and learning, is at the core of medicine’s professionalism movement. However, despite the introduction and subsequent expanded teaching of medical humanities and ethics, and various courses and programs designed to provide students with learning opportunities that are steeped in promoting professionalism at medical schools (Michalec & Hafferty, 2013), Ludmerer (1999) asserts that public charges of physicians being “impersonal, self-serving, greedy, and occasionally dishonest” have been increasing. Medical students do not consider the explicit teaching of professionalism as useful, nor do they see preceptors practicing what they preach (Michalec & Hafferty, 2013). Researchers have argued that medical school and educators need to go beyond factors that are at the individual level, and
address the interpersonal relationships, overarching culture, and organizational climate in not only medical education but also health care that seeps into the training of physicians (Cunningham, Bernabeo, Wolfson, & Lesser, 2011; Lesser et al., 2010; West & Shanafelt, 2007). Medical educators are increasingly interested in the question of whether formal courses are sufficient to instill the sense of professionalism among medical students and increasingly they are answering no (Ludmerer, 1999). They are starting to realize the different dimensions of curriculum in medical school and start to pay attention to the other-than-formal aspects of the curriculum (Kao, Lim, Spevick, & Barzansky, 2003). Medical schools have been implementing formal and informal interventions to cultivate students’ growth at both personal and professional levels (Sharpless et al., 2015). It is under this context that researchers have begun to dissect the concept of curriculum, in relation to which has emerged the concepts of formal curriculum, informal curriculum, and hidden curriculum in medical education literature.

Though not using a clear concept, Snyder (1973) reveals the inconsistency between the formal requirements and implicit expectations that students experience in medical school, and interprets the ‘implicit expectations’ as the “emotional and social surround of the formal curriculum” (p. 4). In Haas and Shaffir’s (1982) analysis of the socialization of medical students, the ‘implicit expectations’ were to present competency and impress preceptors through impression management and the development of communication and negotiation skills. Hafferty and Franks (1994) first introduced the notion of the hidden curriculum in the case of medical education in an article titled ‘The hidden curriculum, ethics teaching, and the structure of medical education’. Hafferty (1998) further acknowledges that many of the learning opportunities in medical education take place “in the elevator, the corridor, the lounge, the cafeteria, or the on-call room” (p. 404). According to Hafferty (1998):

The hidden curriculum highlights the importance and impact of structural factors on the learning process. Focusing on this level and type of influence draws our attention to, among other things, the commonly held ‘understandings’, customs, rituals, and taken-for-granted aspects of what goes on in the life-space we call medical education. (p. 404)

The four areas that Hafferty (1998) urges medical educators to examine are: “policy development; evaluation; resource allocation; and institutional ‘slang’ or nomenclature” (p. 404). In the same article, Hafferty (1998) also defines a relevant concept – the informal curriculum – which “targets learning at the level of interpersonal interactions” (p. 404).

The two definitions have been widely cited in the literature; however, the four areas have rarely been empirically investigated, which, to some extent, illustrates the difficulty of making the informal curriculum or hidden curriculum explicit (Gao, 2015). Hafferty and Castellani (2009) later turned away from the two clear definitions and the distinction between the informal curriculum and the hidden curriculum, and collectively drew medical educators’ attention to four ‘disconnects’ in medical training: “what is taught in the basic science versus clinical years; what is taught in ‘the classroom’ versus ‘the clinic’; what role models preach and what they practice; how formal organizational policies are transformed on the shop floor” (p. 19). The introduction of this new lens into the hidden counterparts to the formal curriculum received an immediate
response from the medical education circle and spawned a large body of literature on the other-than-formal aspects of medical education (O'Donnell, 2014).

Despite medical educators’ best efforts to design learning through an explicit curriculum addressing school-wide objectives (Balmer & Richards, 2014), learning “belongs to the realm of experience and practice, and follows the negotiation of meaning” (Wenger, 1998, p. 225). Skelton (1997) emphasize the notions of “learner experiences” and “educational processes” (p. 188). Skelton (1997) further explains that the hidden curriculum is not merely the living representation of the idealized official curriculum. It is a set of messages mediated by each learner in his or her own way, which can be “contradictory, non-linear and punctuational” (Skelton, 1997, p. 188).

The realization of the disconnects between what medical educators teach and what medical students learn is one of the motivations for reforms in medical education (Hafferty, 2000). The contradictory messages students receive from different types of curricula not only are problematic in terms of their learning of professionalism, but also cause confusion and cynicism among students, which is not beneficial for their life-long learning and future career (Newton et al., 2008). The conflict between the formal rules and the other-than-formal practices has led Hafferty and Tilburt (2015) to suggest that what medical students learn in medical school (what it means to be a successful medical student) may be at odds with what it means to be a good physician. The persistent gaps between formal and hidden curricula, and assumptions and values hidden in plain sight that are learned by students longitudinally call for ongoing examination of medical education practice and medical education reform (Craig et al., 2018).

Within the three types of curricula, the hidden curriculum receives particular attention from research that studies professionalism and professional identity. According to Hilton (2004), “the hidden curriculum...is probably the most important factor influencing development of professionalism” (p. 71). Gao (2015) reveals that the hidden curriculum is not only linked to medical students’ learning of professionalism at an individual level but also the professionalization of medicine at the collective level. The hidden curriculum is commonly operationalized as the following seven elements in medical education literature: “informal curriculum; peer relationship; role modelling; institutional culture; power structure; socialization process; and patient encounters” (Gao, 2015, p. 81). Attention to the informal curriculum, as one theme of the hidden curriculum, illustrates that in some literature, the informal curriculum is seen as a part of the hidden curriculum, which is used as an overarching concept that describes all the elements outside the formal curriculum in medical school.

Research has been documenting the impact of the hidden curriculum on medical students. Medical students need a learning environment that is internally coherent and consistently models professional behaviours and values. Students are immersed in the clinical environment, especially in clerkship years of medical school, which has a very powerful impact on their understanding of professionalism and PIF, through either active or passive enculturation (Lempp & Seale, 2004). Role modelling and faculty development, are two of the identified channels to improve the learning environment (Hendelman & Byszewski, 2014). Students reported witnessing professionalism lapse from not only fellow students but also faculty and
administrative staff, with arrogance being one of the main domains (Hendelman & Byszewski, 2014). Foster and Roberts (2016) observe that what role models say and do have enduring impact, as do everyday events that are powerful and emotionally charged. Just as faculty’s problematic behaviours have the potential for long-lasting undesirable effect, their interest in teaching and building a nurturing and supportive learning environment can be equally powerful (Foster & Roberts, 2016). Research reveals that physicians’ participation in facilitating courses like Mind-Body Medicine, which was reported to decrease students’ stress and increase mindfulness, could also affirm and enhance facilitators’ professional identities (Talisman, Harazduk, Rush, Graves, & Haramati, 2015). The unique nature of medical training makes mentorship essential to learn not only the knowledge and skills, but also the values of what it means to be a physician (Larkin, 2003).

Hawick, Cleland, and Kitto (2018) explore how place and space impact the identity construction of medical students. Students in the study reported feeling pressure to perform within professional boundaries, which led the authors to examine the intersection between students’ calculation of risk to their performance and understanding of professionalism (Hawick et al., 2018). Focusing specifically on the week of orientation into medical school, Craig, Scott and Blackwood (2018) reveal tensions between the overt and hidden curricula in three ‘soft’ aspects of medicine – professionalism, hierarchy and vulnerability, and social difference. Examining from a critical approach, Michalec and Hafferty (2013) argue that the hidden curriculum exists to support two traditional characteristics that are fundamental to the preservation and reproduction of the professional status of medicine: authority and autonomy. Schrewe, Bates, Pratt, Ruitenberg and McKellin (2017) examine medical students’ use of language as they learn to competently participate in the professional world and reveal a series of discursive constructions of patients, including “patient-as-disease-category, patient-as-educational-commodity, and patient-as-marginalized-actor” (p. 656). The authors urge medical schools and educators to minimize the unintended effects by first making these discourses visible (Schrewe et al., 2017).

The analysis of the hidden curriculum within the context of medical education has rarely explored the critical dimensions associated with the origin and elements of the hidden curriculum. Due to their reading habits and citation practice, the quite thoroughly “disciplined” medical experts tend not to explore the writing beyond journals of medicine and medical education (Taylor & Wendland, 2014). Medical educators are inclined to suggest that simple exposure of the existence of the hidden curriculum can resolve its problematic effects. Taylor and Wendland (2014), however, argue that the study of the hidden curriculum requires attention to medical institutions’ structure and culture. Single individuals, no matter whether they are medical students or medical educators, are not responsible for many negative aspects of the hidden curriculum. Nor should we simply call for individuals’ consciousness to enforce the positive influences of the hidden curriculum.

The teaching and learning that takes place in medical school not only is interpersonal and socially constructed but also continues to be refined through external challenges and pressures. Examining medical education practice through dissecting the concept of curriculum and focusing
on the relations between different types of curricula has the potential of conducting a critical analysis that reveals hidden rules that guide actions and experiences. Professionalism and professional identity, as two concrete educational objectives, provide an entry point that not only is significant but also makes the analysis realistic and manageable.

2.6 Literature review summary

Despite the changes made to support medicine’s recommitment to professionalism and facilitate medical students’ development of professional identities, they appear to be superficial efforts by the medical profession or medical school instead of making meaningful and fundamental changes to the ways medical students are educated. The first section in this summary describes the progress made so far, the biggest one being more presence of the two topics in medical education. It also identifies the challenges that continue to confront medical schools and educators, including the competing priorities of medical training and failing to acknowledge the complexity of learning these two areas. In the second section, I review the current knowledge in understanding the relationship between professionalism and professional identity. The similarity in general approaches and specific pedagogies to support these two learning objectives makes it reasonable to study these two topics together. However, though some literature tends to use the two concepts interchangeably, the inclusion of PIF in the literature, to some degree, shifts the expected outcomes from students simply knowing to doing or being. Following this, I provide a conclusion of this chapter, highlighting the research gap in understanding professionalism and professional identity through the lens of curriculum and sociology.

2.6.1 Progress and challenges in teaching/learning professionalism and developing professional identities in medicine

Medical professionalism used to be taught informally from mentor physicians to medical trainees without a formal program. However, as medical education moves towards a competency framework, courses and other learning activities have been added to the curriculum to teach and evaluate professionalism (Cruess, Cruess, & Steinert, 2008). Considerable progress has been made to incorporate the formerly neglected aspects of medicine, including courses on professionalism, ethics, communication, interprofessional practice, and patient-centred care. In spite of all these changes to the curriculum, medical schools still have not done enough in addressing the aspirational dimension of medicine to inculcate “a desire to be more compassionate, more altruistic and more humane” (Cooke et al., 2010, p. 30). These qualities, long used to describe the profession of medicine and physicians, are being revisited in recent years in admission into medical school and in medical training. They together form a commitment to excellence, which is a dimension of the moral identity of physicians (Cooke et al., 2010).

Despite a large body of literature generated on the topic, professionalism still does not have a well-articulated presence within the medical community. It is also much underrepresented in the frameworks of maintenance of certification and continuing professional development (Hafferty, 2018). Curriculum in medical education, and teaching and evaluation practices, tend to neglect
the moral nature of medicine that is fundamental to the practice of medicine and the process of training to become a physician. One of the key challenges facing medical education, as identified by Cooke et al. (2010), is the missed opportunities to allow learners to participate in and appreciate the important nonclinical roles physicians play not only within health care but also more broadly in society. These ‘other roles’ are currently underemphasized in most medical schools, compromising students’ learning experiences and understanding of the full dimension of being a physician, which is partly due to the overemphasis on factual medical knowledge (Cooke et al., 2010). Medicine is also practiced and functions within a complex imperfect health care system. Therefore, medical education should prepare physicians the skills and commitment to address, analyze, and improve the system within which they work (Cooke et al., 2010).

Research concludes that continuing efforts are needed to teach, practice, and assess professionalism. Acceptance into medical school does not guarantee the competencies of a medical professional. What is more concerning is that while medical schools are not doing enough to nurture students to develop the values necessary for the contract between the medical profession and society, many of the values that encompass the moral and social responsibility of medical practice, for example, empathy and compassion, tend to decline during medical students’ training (Hojat et al., 2009). Faculty development is seen as one area to address potential gaps to improve the education on professionalism (Jauregui et al., 2016). Al-Eraky, Donkers, Wijd and Merrienboer (2015) explicitly comment that teaching professionalism is challenging as medical teachers are not prepared to teach this subject matter and professional development has to be available for faculty. Becker (2014) suggests that because many of today’s practicing physicians were trained in a time when formal professionalism curriculum was absent, they may carry some outdated assumptions about the curriculum. Lindheim et al. (2016) conclude that because Millennial medical trainees experience a different formative socialization, their mentors should teach professionalism with approaches that suit their learning expectations.

The emphasis on learning outcomes and producing general competent graduates – the competency movement – has brought three companion problems. The first one is the difficulty in defining and evaluating competencies that are complex, for example, professionalism and PIF. There should be an ‘aspirational’ element, which is different from and complementary to the arena of competencies (Cooke et al., 2010; Jarvis-Selinger, Pratt, & Regehr, 2012). The second is how medical school promotes life-long learning and excellence while the pass/fail system leads to a ‘competent equals good enough’ or ‘meeting the minimal standards of performance’ mentality (Cooke et al., 2010). Lastly, the competency framework poses challenges for medical education to navigate the tension between benefits of diversity and inclusion, and the current dominant discourse of competency and standardization (Sawatsky et al., 2017). Medical education operates under the currents identified above in both health care system and in educational arena, in which goals and objectives are changing all the time and best practices in teaching are always under review and modification. This is reflected by continuing course evaluations and program evaluations initiated by medical schools, which give students a channel to voice their concerns and provide their insights. Some of the feedback from the students have potential for better learning outcomes and can be easily incorporated into further planning of
the curriculum. However, some of the requests, which reveal the individuality of medical students’ experiences and expectations, can be challenging for medical schools to accommodate.

There is still no consensus on how best to integrate the teaching of professionalism and professional identity into medical education, at either theoretical or practical levels (Al-Eraky, 2015; Kao et al., 2003). The teaching of professionalism at the undergraduate medical education level varies widely and the strategies to teach professionalism may not always be effective (Swick, Szenas, Danoff, & Whitcomb, 1999). While trying to fit more courses and lectures on professionalism into the formal curriculum, medical schools often fail to take advantage of the actual situations that students and health care professionals encounter on the wards and use them as teaching and learning opportunities (Francis, 2004). Due to its complex and context-specific nature, professionalism is still a competency in medical education that is challenging not only to define and teach, but also to assess (Bryden, Ginsburg, Kurabi, & Ahmed, 2010; Hafferty & Castellani, 2010; Swick, 2000).

Al-Eraky (2015) draws educators’ attention to context and networking, in addition to teachers and curriculum, in teaching medical professionalism. One of the specific tips provided by Al-Eraky (2015) is that professionalism has to be defined through the view of each institution with its own cognitive base that acknowledges not only the universal expectations and obligations between medicine and society, but also manifests the accountability of the institution to address the needs and concerns of the community or region it promises to serve. Nurturing a professional identity that integrates the many dynamic dimensions of medical professionalism, requires more than the seemingly straightforward process of defining, assessing and institutionalizing professionalism in medical practice and medical school. As Hafferty (2018) summarizes well, “medical educators, ever so slowly, began to realize that creating definitions, crafting assessment tools, and generating new curricula was a lot easier (and more productively seductive) than painstakingly effecting changes in the culture of medical practice” (p. 533).

2.6.2 The relationship between professionalism and professional identity in medicine

It is common for literature on professionalism to obscure the concept or goal of PIF through emphasizing attitudes and behaviours that are driven by expectations to maintain professional standards (Foster, 2009; Hilton, 2004). Some literature uses professionalism and PIF interchangeably and seems to suggest that the formation of professional identity will naturally come as a result from teaching professionalism (Olive & Abercrombie, 2017). In this sense, teaching medical professionalism is a means to the end goal of PIF (Cruess, Cruess, Bourdreaux, Snell, & Steinert, 2015). Identity formation is also discursively operationalized as professionalism in some medical education literature (Jowsey, 2018). However, identity formation, as a conceptual lens, prompts a more complex formulation. Barnhoorn (2016) comments that as PIF appears in the literature it seems to have supplanted the concepts of professional behaviour and professionalism. However, Barnhoorn (2016) suggests that professionalism and professional identity are not successively achieved goals but intertwined.
There were attempts in the literature to unpack, either directly or indirectly, the relationship between professionalism and PIF in medicine. In investigating clinicians’ and managers’ responses to scientific-bureaucratic medicine, which is manifested in the National Institute of Health and Clinical Excellence guidelines in the UK, Spyridonidis and Calnan (2011) reveal three themes: conditional acceptance of the guidelines with an emphasis on organizational values; rejection of the guidelines and the emergence of proactive or entrepreneurial professionalism; and resistance to the guidelines with an emphasis on the prominence of clinical autonomy. Spyridonidis and Calnan (2011) further argue that such responses reflect the development of multiple occupational identities rather than a significant emergence of new forms of professionalism. Medical students have shown a number of “direct and indirect, verbal and bodily, instantaneous and delayed forms of resistance” (Shaw, Rees, Andersen, Black, & Monrouxe, 2018, p. 45) when facing professionalism lapses of their seniors to protect patient and student interests. These reactions help students make sense of their position and develop their professional identities and, in the long term, enable them to promote the transformation of the dominant medical structure and culture.

Some educators have been challenging the behavioural pedagogical approach to medical professionalism and advocating for developing and sustaining deeply held attitudes and values that contribute to PIF (Shapiro, Nixon, Wear, & Doukas, 2015). According to Shapiro et al. (2015), “Medical students must learn how to be good doctors, rather than merely to act like good doctors” (p. 2). Researchers have also argued that behavioural professionalism can tempt students to perform surface impression management to fulfill others’ expectations of professionalism (Cohen, 2007; Rees & Knight, 2007). Lucey and Souba (2010) relate this to the definitional issue with professionalism and comment that in clinical settings, professionalism is defined as a technical problem in a simplistic and narrow manner that is rules-bounded with prescriptive and mechanical solutions.

The general approaches and specific pedagogies for the two learning objectives can be integrated to complement each other. Cruess et al. (2015) explain that the experience gained from teaching professionalism, which includes longitudinal integration of the curriculum, self- and guided-reflection, and a cognitive base that outlines the nature of professionalism, could be beneficial for promoting and guiding identity formation. However, the difference in the verbs used in these two educational activities – teaching versus promoting and guiding – illustrates the difference in the two end goals. Miller’s (1990) pyramidal structure with four levels of assessment – ‘knows’, ‘knows how’, ‘shows how’, and ‘does’, have been used to assess competency of professionalism. However, Cruess, Cruess, and Steinert (2016) propose that a fifth level ‘is’ should be added as the incorporation of professional values and attitudes should be a more reliable indicator of professional behaviour. Hafferty (2016) has also argued 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 transition from ‘knows’ and ‘does’ to ‘is’ uniquely captures the relationship and difference between professionalism and professional identity.
2.6.3 Literature review conclusions

Understanding how medical students learn professionalism and develop professional identities is particularly significant when the curriculum reform in medical education aims for a more team-oriented approach to health care and a less hierarchical working environment among health care professionals. According to Wear, Zarconi, and Garden (2014), professionalism, represents a “vaguely positive-sounding floating signifier” (p. 64) that medical educators, medical schools, and accrediting bodies deploy with symbolic intention. The same argument could be made about PIF as well. These terms are easily accepted to illustrate that the medical profession pays close attention to associated virtues, such as respect, empathy, and altruism, which allow it to claim a moral high ground for the practice of medicine and medical education (Wear et al., 2014). It is, in this sense, crucial to understand how medical students’ learning of professionalism and formation of professional identity are influenced by both different types of curricula and other players within the medical education field. It is also important to analyze students’ learning experiences to understand the relationship between learning professionalism and developing professional identity.

There is very limited literature that examines all three types of curricula with a focus on professionalism and PIF, especially from a sociological perspective. Determining the relationship between students’ learning of professionalism and PIF and curricular content can support the development of effective interventions and programs in medical schools, facilitating better learning experiences with professionalism and robust PIF. The expectation is an appreciable alignment between mission statements and practical actions of medical schools, with the informal or hidden curriculum functioning in a manner that enhances the formal curriculum (Hafferty & O'Donnell, 2014). The next chapter examines the previous analytical work in sociology on the research questions and introduces the theoretical framework that guides this study.
CHAPTER 3 THEORETICAL FRAMEWORK

3.1 Introduction

This chapter first reviews the theoretical approaches that have been utilized in sociology to understand the issues of learning professionalism and PIF in medical education. This discussion reveals how these phenomena, which were initially understood mainly in relation to the study of professional socialization in medicine and the debate between structural functionalism and symbolic interactionism, have come to be analyzed in more complex ways over time. This is followed by an explanation of the theoretical significance of this study, which is to take a systematic approach towards medical students’ learning experiences with professionalism and professional identity through analyzing institutional practice and educational processes. I then move on to introduce the theoretical framework utilized for this study, which is a combination of Giddens’s (1984) structuration theory, and Lave and Wenger’s (1991) theory of communities of practice.

3.2 The development of the sociology of medical education – a theoretical review

Owing to a number of developments within medical education, including the need to incorporate a growing body of knowledge within limited curricular time, innovations in medical curricula and the development of systematic research to understand medical education, and sociological interest in professions, organizations and adult socialization processes, the sociology of medical education started to emerge as a research agenda within medical sociology in the 1950s (Merton et al., 1957; Hafferty, 2000). According to Hafferty (2007), “the study of medical education as a process of professional socialization” (p. 2930) helped to legitimize the academic field of medical sociology.

To analyze the socialization aspect of medical education, different sociological perspectives have been employed. Merton et al. (1957) adopt a structural-functionalist approach and portray the socialization of medical students as a straightforward process. The analysis describes the gradual assimilation of medical students into the professional world of medicine and emphasizes the significance of institutional stability, which is maintained by the contributions of the different units within the medical education system (Merton et al., 1957; Hafferty & Castellani, 2009). The socialization process, in this sense, is not only important to the development of individual medical students, but also central to the function of the medical education as a system within the profession of medicine (Gao, 2015). Becker et al. (1965) put medical students’ daily experiences above the function of professional socialization for medicine, which makes it possible to discover strategies that students adopted to survive medical school, conceived as an institution of higher learning. Becker et al. (1961) also reveal competing versions of reality between faculty and students, the latter of which navigated expectations of the former and constructed meanings of their experiences (Bloom, 1965; Brosnan, 2009).
Both perspectives provide an accurate account of medical training, depending on which dimension one decides to examine (Bloom, 1979; Light, 1980). Hafferty (2007) observes that while the Merton team conducts their study from a structural functional approach and the Becker team operates their research from a symbolic interactionist perspective, both studies are less about the normative impact of medical school training than opportunities to advance competing theoretical perspectives. However, despite an auspicious beginning with the work of both Merton et al. (1957)’s and Becker et al. (1961)’s, the sociology of medical education, which did not manage to influence medical education significantly or keep up with the theoretical developments in broader fields, has remained marginal to the discipline of sociology (Brosnan & Turner, 2009). At the same time, progress continues to be made within medical sociology. Freidson (1970, 1974), in his ground-breaking work of Profession of Medicine: A Study of the Sociology of Applied Knowledge and Professional Dominance: The Social Structure of Medical Care, argues that the structural organization of medical practice and work environment have a much bigger impact on physician behaviour than does prior socialization. This argument, in part, contributed to the shift in the sociological study of medicine “from a more micro focus on professionalism and identity transformation to a more macro focus on organizational dynamics and structural change” (Hafferty, 2007, p. 2930). Similarly, Light (1988) calls for a new sociology of medical education to expand the interest on professional socialization to institutional and comparative analysis.

Efforts have been made in this regard to adopt a more critical approach to the study of medical education. Researchers started to conceptualize medical education as an interactional process and investigate the performative efforts of medical students due to external expectations to appear professional and competent. Knowledge, skills, and values are not only acquired by but also ultimately are reproduced by medical students (Atkinson, 1981; Brosnan, 2009; Sinclair, 1997). However, some researchers have argued that these attempts still view medical school as secondary to individual medical students and their traits (Brosnan, 2009). The power of medical school and the external structures impacting the organization of medical education are still not taken into consideration (Bloom, 1979;). Bloom (1979) observes a shift in the late 1970s “from the social psychology of individual development to scrutiny of the bureaucratic nature of the organization of the modern medical centre” (p. 16) and notes further that research in medical education starts to focus on power structures and decision-making processes in medical school.

According to Bloom (1979), student learning has become a unique topic and variable in the study of medical education, eventually drawing researchers’ attention to the influence of the learning environment in medical school. Light (1983) argues that these insights contribute to a shift in teaching philosophy from faculty teaching to student learning, with medical students being regarded as colleagues and maturing individuals who are responsible for their own education. Another issue in medical education that is examined at an institutional level is curriculum reform that attempts to first integrate the pre-clinical and clinical phases to underline the importance of the application of knowledge and skills (Brosnan, 2009), and then reinforce the professional values associated with the medical profession (Wear & Castellani, 2000). These institutional changes are, however, only symbolic and characterized as “reform without change” (p. 294) by
Good & Good (1993) with their discovery of medical students’ continuous concentration on learning scientific facts and presenting competence. According to Fox (1990):

A review of past efforts to modify medical education reveals that most of the problems...are not new. Institutions intermittently have changed their curricula, but unfortunately little progress has been made toward a fundamental reappraisal of how physicians are educated. Thus, we do not claim novelty in the discovery of deficiencies. (p. 213)

Bloom (1988) argues that even though both curriculum in medicine and medical practice have undergone radical changes, the teaching experiences for faculty and learning experiences for medical students remain the same. Vinten-Johansen and Riska (1991) also argue that curriculum reform is used as a strategy by the medical profession and medical schools to maintain autonomy and express its social commitment when faced with external intervention and criticism. It is therefore of value to understand not only the resistance to change at an institutional level but also how some of the institutional changes and practices serve only token functions.

Over the past decades, sociological theoretical frameworks have been applied to the study of medical students’ socialization, representing further exploration of the impact of learning environment on medical education. For example, Bourdieu’s theory of thinking relationally about social practice and key concepts of field and habitus have been utilized in some research (Brosnan, 2009; Gao, 2015). Sinclair (1997) reveals a set of dispositions that essentially form a medical habitus, which is necessary for the success in the profession of medicine. Using Bourdieu’s concept of habitus, Luke (2003) explains how professions reproduce themselves in the form of durable dispositions. Lempp (2009) concludes that though the medical habitus that students develop could produce competent practice, they could also suppress caring dispositions. Power structure in the field of medicine is also, to some extent, explored by researchers, especially with attention to the hierarchy in the medical profession and the power imbalance between medical educators and medical students (Gao, 2015). Michalec (2011) argues that some of the hidden curriculum in medical education – e.g. medical students being told they are of more social worth than others – has potential for separateness and distinction. They foster distance between physicians and patients, as well as physicians and other health care professionals, and further establish status hierarchy and stratification, which are in direct contradiction to the ideals of professionalism (Michalec, 2011). Many of the strategies that students develop during medical school are not motivated by the desire to become competent and professional practitioners but rather by the pressures to impress their medical educators and fit in their learning environment to succeed in medical school (Gao, 2015). As the problematic dispositions become a part of medical students’ habitus, the hidden curriculum could undermine the stated goals of the formal curriculum (Hafferty & Castellani, 2009).

Even though progress has been made, agency is often privileged over structure in analysis. An analytical gap exists in the treatment of organizational structure and medical students’ socialization as two separate phenomena. In connecting the hidden curriculum to several important sociological concepts, including discourse, power relations, socialization, and social institutions, Hafferty and Castellani (2009) propose the hidden curriculum as an analytical
framework. In differentiating the formal curriculum from other forms of learning, Hafferty and Castellani (2009) note the distinction “between official workplace rules and the more informal normative practices that govern work on the shop floor” (p. 25). In relating medical education to sociological literature on socialization, professional culture and identity formation, Hafferty and Castellani (2009) make explicit “the differences that exist between surface (or manifest) social phenomena versus the ‘deep structures’, the ‘underlying grammars’, ‘cultural codes’, or the ‘generative rules’ that underscore social action” (p. 25). Hafferty and Castellani (2009) further acknowledge that “…everyday social action, because of its mundane and taken-for-granted nature, readily unfolds beneath the reflective radar of individuals and therefore exerts its influences at a pre-, sub-, or unconscious level” (p. 25). This study is informed by the research of Hafferty and Castellani (2009) and slightly modifies Hafferty’s (1998) classification of the curriculum into the formal curriculum, informal curriculum, and hidden curriculum, and their definitions (see methodology on data collection).

3.3 Theoretical significance of the study – sociology’s contribution to medical education

According to Brosnan & Turner (2009), the empirical studies on professional socialization of medical students are mostly ethnographic inquiries conducted in single medical schools, which are too disparate to advance a coherent sociology of medical education. There had been no research monograph providing an overview of the area since the work of Merton et al. (1957) until the publication of the Handbook of the Sociology of Medical Education in 2009. At the same time, the emergence of medical education as a distinct research area with its own journals and conferences raises the question of whether we still need a sociology of medical education (Brosnan & Turner, 2009). To bring alive the field of the sociology of medical education, much greater theoretical engagement with mainstream sociology is needed (Brosnan & Turner, 2009).

As sociology is critically oriented to consider the full spectrum of social processes, it contributes significantly to the conceptual analysis of medical education, especially by framing it as a social process that takes into consideration the impact of social structures and the active involvement of participants. Medical education is not something medical schools can simply teach or deliver; rather, it is a system constructed by the intersection of different types of curricula, which exert a dynamic web of influences on medical students (Hafferty & Castellani, 2009). The learning environment is complex, self-organizing, evolving, and adaptive, and contributes to a whole which is more than the sum of the different parts (Capra, 2002). A sociological approach, which intends to understand not only how but also why, can help to strengthen medical education studies that aim to improve the process and outcome of medical education.

There have been dramatic changes in health, health care, and the medical profession since the early sociological accounts of medical students’ learning experiences were conducted. Researchers increasingly are exploring questions of professionalism and professional identity in medical education in relation to the process of social learning (Sullivan, 2016). However, these calls for a new professionalism or recommitment to the medical professionalism, or the formation of a professional identity, are absent from the sociology literature (Hafferty & Castellani, 2011). In discussing the rise of the professionalism movement within modern
medicine and medical sociology’s disappearance from the professionalism debate, Hafferty and Castellani (2011) suggest: “medicine’s embrace of professionalism as a de facto social movement offers sociology a myriad of possibilities to develop its sociological gaze – and that this gaze, in turn, can provide new insights into medicine’s evolving status as a social institution” (p. 214). This study intends to understand professional socialization of medical students, with a specific focus on professionalism and professional identity, not only at an interactional level but also at an institutional level, which takes into account the practice of medical school.

The theoretical objective of this study is to apply theoretical frameworks and concepts drawn from mainstream sociology to the understanding of medical education. Utilizing both theoretical and methodological tools in sociology, this study intends to find an approach to the study of medical education that integrates the impact of structure and the potential of agency. On an empirical level, the study intends to bring together the micro focus on professionalism and professional identity and the larger-scale understanding of how these phenomena are related to organizational power and dynamics. Though the focus of this study is to understand medical students’ learning experiences, I utilize a systematic approach towards their individual views on medical professionalism and the processes through which they internalize professional identities. The objectives are: to explain how individuals and the institution in which they study are shaped by each other; to explore how participants within a given community construct and negotiate their daily activities; and to achieve a system-level view of medical education and propose changes that are possible at both individual and institutional levels. To achieve these objectives, I apply a combination of Giddens’ (1984) structuration theory of understanding the complexity of social practice, and Lave and Wenger’s (1991) understanding of the context of social practice – community – to help explain students’ of professionalism and professional identity in medical education. The following sections explore these two theoretical approaches in more detail.

3.4 Structuration theory and tacit knowledge

3.4.1 Overview of structuration theory

The utilization of the dialectic of agency and structure in understanding change and development in social systems has a long tradition in sociology. Giddens’ (1984) theory of structuration is one of the most important attempts at integrating agency and structure. Giddens (1984) draws on the theoretical frameworks of Erving Goffman and Harold Garfinkel and provides a response to the shortcomings of Parsons’ theory of functionalism (Allan, 2013). According to Giddens (1984), the social system cannot operate without the knowledgeable activities of individuals. Therefore, a theory of the acting subject should consider the competences and rational self-consciousness of individuals, although Giddens (1984) also argues that there are dimensions of society that cannot be fully explained by the actions of individual actors and social theory should account adequately for institutional realities.

In Giddens’ analysis, the agency and structure divide is a false dichotomy with both acting as two facets of a single phenomenon to explain the complexity of human practice (Morrison, 2005).
Integrating the elements of human action and structural explanation in social analysis, according to Giddens (2002), should have the following three dimensions: “a theory of the human agent, or of the subject; an account of the conditions and consequences of actions; and an interpretation of ‘structure’ as somehow embroiled in both those conditions and consequences” (p. 232). Giddens (1984) argues that agency and structure are recursively produced, which means they are continuously constructed at the same moment through the same behaviours. Instead of viewing structure and agency as two mutually exclusive elements, Giddens (1984) proposes the concept of a duality and sees them as two analytically distinguishable parts of the same thing. Structuration refers to the process through which social actors reproduce the systems through their activities (Giddens, 1984). The duality of structure illustrates that structure not only provides the medium for but also is the outcome of social conduct that it reflexively organizes (Giddens, 1984). The structuration theory is ultimately an effort to transcend the dual orientations of interactionist and functionalist thinking and takes into account both agency and subjective meaning, and the operation of social systems and the resilience of objective structures (Allan, 2013).

3.4.2 Tacit knowledge

To develop a theory of social actors in interactions, Giddens (1984) identifies three important components: reflexive monitoring of action, rationalization of action, and motivation for action. These tasks are seen by Giddens (1984) as stratified and therefore require different levels of awareness (Allan, 2013). The reflexive nature of actions requires actors to monitor the behaviours of others and their interactions with others and keep track of the consequences of their own actions. In accomplishing this, actors provide a rationalization of their actions (Giddens, 1984). Giddens (1984) distinguishes between three types of consciousness, unconscious, practical consciousness, and discursive consciousness, which are specifically developed to understand the nature of social knowledge (Haugaard, 1997). Unconscious motives that provide the sources of our wishes and desires are, by definition, repressed from conscious awareness or seep in distorted form into consciousness. Therefore, actors are typically unable to offer a discursive account of their unconscious motivations (Appelrouth & Edles, 2008). Discursive consciousness refers to the ability to verbally communicate the analytical reasoning of our actions and represents actors’ awareness of the reflexive monitoring of social encounters and rationalization of social actions (Giddens, 1984). Practical consciousness is an integral component to understand the balance between social actors who are reflexive and knowledgeable agents but are not able to create social systems deliberately (Haugaard, 1997). According to Giddens (2002), practical consciousness consists of tacit knowledge “that is skillfully applied in the enactment of courses of conduct, but which the actors are not able to formulate discursively” (p. 234). The tacit knowledge enables actors to ‘go on’ in everyday social life – to exist and behave socially (Giddens, 1984). Giddens (1984) further argues that practical consciousness contributes to the construction of routines and the type of social knowledge actors use to engage in structuration is mostly practical consciousness instead of discursive consciousness. Routinization, an important concept in structuration theory, describes the process through which social actions become habitual and taken-for-granted (Giddens, 1984). This study focuses on these two forms of consciousness – discursive and practical – and the alignments and gaps between them.
Curriculum is a stock of educational knowledge that is transmitted by teachers and internalized by students. With curriculum reforms in medical schools, we see progressive incorporation of community-based practice, public and global health, and social determinants of health into the core curriculum (Atkinson & Delamont, 2009). With the professionalism movement in medicine, we also observe that the discourses of professionalism and professional identity have more presence within the curriculum (Sullivan, 2016). However, research has shown that classroom lectures are not the most effective method of instruction in these topics; the learning of these topics is more effective in experiential formats through observation, reflection, and role modelling (Cunningham et al., 2011; Michalec & Hafferty, 2013; Sharpless et al., 2015). The other-than-formal aspects of medical training, which are not simple to articulate or easy to investigate, are central to medical students’ learning experiences with professionalism and professional identity. I hypothesize that it is often through tacit knowledge that students establish their understanding of medical professionalism and develop their professional identity. At the same time, just as there exists forms of social life in educational institutions (Bernstein, 1971), there exists social knowledge on how to be successful in medical school, including how to fit in the learning environment and what it means to be a professional physician.

The different types of curricula related to professionalism and PIF provide a set of rich data to examine practical consciousness and discursive consciousness in medical education. Medical students learn not just in the classroom or from the formal curriculum. Their learning experiences throughout the four years of training, including the factors of cohort impact, patient encounter, and role modelling, all contribute to their understanding of medical professionalism and PIF. Medical school delivers both explicit and tacit knowledge to medical students; however, the gap between them can significantly undermine the explicitly stated aims of the formal curriculum. Because of the curriculum gaps that provide mixed or contradictory messages and expectations, the ideals and best practices that are often delivered through the formal curriculum may not be internalized by students. At the same time, because the informal curriculum does not support the formal curriculum, students may not have enough opportunities to practice the knowledge and skills to meet certain learning objectives.

3.4.3 Structuration, institutional practice and power

Giddens (2002) argues that structures do not exist in time or space but in the moments of the constitution of social system, which is a structured totality. According to Giddens (2002), the most deeply-layered practices that are constitutive of social systems are institutions. In analyzing the historical duration of the practices that structures recursively organize and the spatial breadth of those practices we can see the deep layers of structures (Giddens, 2002). Social systems not only have structures and structural properties, but also involve the situated activities of human subjects (Giddens, 2002). According to Giddens (1981), “all human action is carried on by knowledgeable agents who both construct the social world through their action, but yet whose action is also conditioned and constrained by the very world of their creation” (p. 54). In this sense, social systems are essentially regularized relations of interdependence between individuals or groups and should be best analyzed as recurrent social practices (Giddens, 2002). In Giddens’ (2002) words, “To study the structuration of a social system is to study the ways in
which that system, via the application of generative rules and resources, and in the context of unintended outcomes, is produced and reproduced in interaction” (p. 237).

The concept of power occupies a central status in Giddens’ structuration theory. Giddens (2002) rejects both Weber’s conceptualization of power as an actor’s capability to achieve his or her will and Parsons’s framing of power as a property of the collectivity and instead argues that the two views should be connected as features of the duality of structure. According to Giddens (2002): “Power is generated by definite forms of domination in a parallel way to the involvement of rules with social practices; and, indeed, as an integral element or aspect of those practices” (p. 238). Rules are not the creation or property of isolated individuals – their existence transcends individuals. Rules – the shared and collective recipes of know-how only exist as people apply them (Appelrouth & Edles, 2008). It is also important to note that “rules may be consistently or rarely invoked, tacit or discursive, informal or formal, and weakly or strongly sanctioned” (Allan, 2007, p. 389). As people reproduce the rules, they reproduce the broader social systems in which these rules operate and in which their actions take place (Appelrouth & Edles, 2008).

Medical education and a medical school can both be analyzed as social systems with their own rules. Medical students’ learning, as a social practice, is situated within these systems and regulated by their established rules and expectations. Though the learning of professionalism and PIF have become two established goals of medical education across Canada, individual medical schools still have a lot of discretion about how students are taught on these two subjects. Elements of how much time they dedicate to relevant courses, how they define the concepts, and how they organize the curriculum are determined by individual medical schools and directly impact students’ learning experiences. These elements produce a structure within which medical education is delivered and define dominant knowledge and skills that are valued and evaluated by medical schools. The informal teaching and learning is an embedded component of the structure of clerkship and depends on students’ interactions with others. It further enhances the established rules and expectations of the profession as students are fully immersed and actively participate in the learning and working environment. However, despite the structural elements that are provided to guide learning on professionalism and PIF, students might not adhere to these best practices. They may develop strategies to make sense of and draw on them in their own ways. In studying the formal and informal curriculum on professionalism and PIF and medical students’ experiences with them, with a specific focus on the alignments and gaps between them, we can understand and explain how institutional practices and expectations on professionalism and professional identity are produced and reproduced in medical schools. The next section further situates medical students’ learning within the community of medical practice and discusses its significance to the concept of professional identity.

3.5 Socialization, community of practice, and identity

3.5.1 Socialization in medical school
The learning of professionalism, and the formation of a professional identity, are ultimately dimensions of the process of socialization. Though the most intensive analysis of socialization as internalization of values has concerned the years before higher education when the primary social environment is the family or primary or secondary schools, Parsons and Platt (1970) identify an important stage of socialization, which they refer to as “stendentry” (p. 9) – socialization in higher education. The experiences of students in the system of higher education could be examined through the framework of social organization of learning, which includes two intertwined but distinct processes: “the process of assimilating the cognitive content of subject matter and methods of dealing with cognitive problems; and the process of internalizing the values and norms of the social systems of reference as part of the noncognitive, if not nonrational, structure of personalities” (Parsons & Platt, 1970, p. 32). The latter, which is “ordinarily called socialization” (Parsons & Platt, 1970, p. 32), is the focus of this study. Medical school, a classic example of professional schools in higher education, is the institutional context in which medicine’s professional standards set the agenda for learning (Hafferty, 2016). Medical school is a complex educational process through which advanced practitioners communicate expert knowledge and judgment. Through the process the medical profession also puts its defining values and exemplars on display with the intention that future practitioners can begin to assume and examine their future identities (Hafferty, 2016). It is desired that medical students turn out to think, act, and feel like physicians with characteristics that are expected by the medical profession (Merton et al., 1957).

Medical school is a unique component of higher education: on the one hand, it resembles graduate school (for example, to apply for the CoM, applicants need to have completed, or be in the last year of, a four year degree program); on the other hand, it is quite different from other graduate schools and resembles secondary schools (for example, medical school sets strict timetables; medical students have instructors instead of supervisors and have big classes instead of seminars; medical students are also very close to their peers in the same cohort). Medical students are grown-ups who have a clear career pathway ahead of them. At the same time, they are under constant assessment to be determined whether they can continue to work towards their anticipated career. All these factors contribute to a distinct identity as a medical student, a necessary transition from medical students to medical practitioners, and medical students being more closely related to their educational institutions through all types of curricula.

According to Baszanger (1985), to better understand the training and socialization of medical students, we need to further explore how the proposed and commonly held model of understanding and practicing is conformed to by new members. We also need to reveal the active roles that participants play in the implementation and effectiveness of the means of reproduction of medical culture. As Hafferty (2016) argues, medical school is one of the mechanisms through which the organized medical profession can exert significant control because of its power to control both the selection and education of future physicians. This study also aims to explain how the professional socialization of medical students serves a social control function and the relevance of such control for their future medical practice. The main question to be answered from this approach is how much the medical profession or medical school controls the transformation from medical students to medical practitioners and through what mechanisms.
3.5.2 Communities of practice, participation and identity

Medical school provides not only a channel of socialization for medical students but also a community of practice for learning and transformation. The theory of communities of practice and its associated concept of situated learning, developed by Lave and Wenger (1991) and Wenger (1998) while studying apprenticeship as a learning model, provide a social learning theory that could help explain the process of acquiring a professional identity in medical education (Cruess et al., 2015). The primary focus of this theory is on learning as social participation (Wenger, 1998). This theoretical approach, with its roots in the pragmatist tradition, is compatible with Giddens’s (1984) emphasis on the importance of action, carried out by knowledgeable actors, for social theory. Knowledge is not only a matter of the competencies that are unique to valued enterprises, but also a matter of participating to pursue those enterprises. Participation, according to Wenger (1998), refers:

not just to local events of engagement in certain activities with certain people, but to a more encompassing process of being active participants in the practices of social communities and constructing identities in relation to these communities. Participation in a playground clique or in a work team, for instance, is both a kind of action and a form of belonging. Such participation shapes not only what we do, but also who we are and how we interpret what we do. (p. 4)

According to Wenger (1998), a practice that people develop to be able to do their job, is always a social practice. Through doing their job, they constitute a community of practice (Wenger, 1998). In Wenger’s (1998) own words, “The concept of practice connotes doing, but not just doing in and of itself. It is doing in a historical and social context that gives structure and meaning to what we do” (p. 47). Communities of practice theory is a learning theory that has a strong relationship to the social construction of knowledge (Lave & Wenger, 1991). Wenger (1998) further acknowledges that the concept of practice can be both explicit and tacit. According to Wenger (1998):

It (Practice) includes what is said and what is left unsaid; what is represented and what is assumed. It includes the language, tools, documents, images, symbols, well-defined roles, specified criteria, codified procedures, regulations, and contracts that various practices make explicit for a variety of purposes. But it also includes all the implicit relations, tacit conventions, subtle cues, untold rules of thumb, recognizable intuitions, specific perceptions, well-tuned sensitivities, embodied understandings, underlying assumptions, and shared world views. Most of these may never be articulated, yet they are unmistakable signs of membership in communities of practice and are crucial to the success of their enterprises. (p. 47)

Communities of practice provide the prime context in which people work out tacit practice/knowledge through mutual engagement. The social and negotiated character of both the explicit and the tacit is highlighted in the concept of practice (Wenger, 1998). This view is also shared by Giddens (1984), who emphasizes social actors’ reflexive monitoring of social actions and the role of practical consciousness that allows them to exist and behave socially.
When people who share a common body of knowledge engage in activities to apply the knowledge, they create a community of practice (Wenger, 1998). The medical profession is a community of practice. Medical students are those who wish to share the common body of knowledge in medicine and engage in learning activities – medical education – to become competent in the defined field of medicine. PIF is a dynamic process that happens simultaneously and results in medical students joining the medical community of practice (Cruess et al., 2015). Because medical education takes place within defined domains, it is situated learning (Lave & Wenger, 1991). Lave & Wenger (1991) emphasize the importance of social interaction between individuals in the community that promotes learning. The transformation from a member of the lay public to a medical student, and eventually a medical professional, describes the move from non-legitimate status to legitimate peripheral participation, and eventually full participation in the community (Lave & Wenger, 1991). Full participation in the community requires a sense of belonging and an acquisition of the identity associated with the community (Lave & Wenger, 1991; Wenger, 1998). Every medical student who wishes to join the medical community must adhere to its rules and norms that change over time as failure to do so could inhibit progress to full membership or lead to exclusion from the community, which, to some extent, illustrates the mechanisms of social control and ruling relations in medical school (Cruess et al., 2015; Vignoles, Schwartz, & Luycks, 2011).

3.6 Summary of theoretical framework

This study takes a critical approach to understand the process of socialization of medical students in learning professionalism and developing professional identities. Structuration theory and several of its key concepts – tacit knowledge, institutional practice, and power – work well to analyze the relationship between the actions of individual medical students and faculty and the stability of social systems of medical education and medical school. These concepts can also help to explain the social construction of knowledge as represented in the curriculum in medical school and how different types of curricula operate with various mechanisms to make an impact on students’ learning experiences in medical school. The theory of communities of practice and its connection to professional identity through participation situate medical students’ learning within a particular domain. In this domain, the expected knowledge, skills, and values are established through the formal curriculum but also practiced by participants, whose actions form the informal and hidden curricula. These two theoretical perspectives can complement each other in understanding the processes and consequences of the transition from medical students to medical practitioners, and informing changes for future teaching practices at medical school. The following chapter is dedicated to introducing the methodology utilized for this study – institutional ethnography – and its associated concepts, and how this methodology aligns with the research objectives of this study, both theoretical and empirical.
CHAPTER 4 METHODOLOGY

4.1 Introduction

In this chapter of the dissertation, I introduce the methodology that is utilized for this study. In the first section, I provide an overview of research methodology, which is Dorothy Smith’s (2005) institutional ethnography. In the second section, I describe some theoretical considerations of IE that are relevant to this study and discuss how IE could help to achieve the theoretical and empirical objectives of this study. I then move on to outline the data collection and data analysis approaches. Finally, a conclusion section on the methodology chapter is provided.

4.2 Overview of research methodology

This study seeks to understand the complex nature of educational processes in medical schools, emphasizing the way in which the curriculum, understood as a totality consisting of the formal, informal, and hidden curricula, makes an impact on students’ learning of professionalism and PIF. Qualitative data are crucial to this research because they make it possible to reveal medical students’ perceptions and provide detailed accounts of how they interpret their daily activities and experiences. The setting in which this study is undertaken is a medical school, understood as a social institution. The methodology of this study is also guided by the theoretical purpose to take a systematic approach towards institutions’ influences on various groups of participants as well as the interpersonal relationships among members of these groups. This study utilizes IE as the overall methodology because this approach makes it possible to integrate these various focal points.

IE is a method of inquiry that examines social relations and social institutions through everyday experiences, or as Smith (2005) puts it, through “local actualities of the everyday world” (p. 24). Due to the limited time and resources available to sustain a PhD project, this research is conducted at one medical school, which is the College of Medicine (CoM) at the University of Saskatchewan (UofS). Examining medical education from a sociological perspective and as an outsider, I have the unique opportunity to treat participants’ experiences with and expertise in managing their work as research data and critically analyze the social and ruling relations in medical school. While my position did not enable me to have the full experiences and perspectives that medical students would likely develop, it did offer me insights that might otherwise not be possible for those negotiating the daily demands of medical education. Under the methodology of IE, I utilize document collection, participant observation and individual in-depth interviews as three data collection methods, and thematic analysis and mapping as two methods of data analysis. To conduct participant observation and individual interviews, this study was approved by the Behavioural Research Ethics Board at the University of Saskatchewan in April 2017. The following sections of this chapter introduce and justify the utilization of IE and the chosen methods of data collection and data analysis in more detail.
4.3 Theoretical considerations of IE

IE is an approach to inquiry developed by sociologist Dorothy Smith (2005). According to Walby (2013), “IE is neither a theory nor a methodological technique per se; it is more like an agenda for inquiry that is guided by particular theoretical and methodological commitments” (p. 141). IE closely studies individual activities, but it goes beyond individual-level explanations of problems and phenomena (Ng et al., 2017). IE is useful in making visible the social relations that underpin individual experience. In other words, IE has the “capacity to uncover linkages between local social settings and extra local settings that lie beyond our immediate experience” (Ng et al., 2017, p. 52), which gives an institutional nature to people’s everyday experiences. IE not only explores the coordination of people’s work that is embedded within institutional orders through text (Quinlan, 2009), it also maps the social relations that organize people’s everyday worlds with the aim of transforming those social relations (Miller, 2015).

In relation to the theoretical framework outlined in the previous chapter, I also draw upon Smith’s theoretical understanding of several conceptual tools for looking at and investigating everyday life, which include social relations, work, and ruling relations. Social relations are constituted by actual practices and activities through which people’s daily lives are socially organized. They also extend from courses of action that take place across social settings. People act competently and knowledgeably to participate actively in social relations as they coordinate their performance with professional standards or organizational rules (Campbell & Gregor, 2002). This understanding is shared by Giddens (1984), who emphasizes the reflexivity and knowledgeable of social actors in his explanation of structuration theory. Within a given structure, social actors draw upon the pre-existing rules and resources to construct their experiences.

Work is defined in a particular way in IE, referring to activities that people engage in that take not only time but also effort and intent (Smith, 2005). Work also takes place in a concrete place with definite conditions and particular rules (Miller, 2015). In other words, people need work knowledge to do what they do. Smith (2005) also explains how ruling is constructed and connected to objectified knowledge. According to Smith (2005), ruling relations are “forms of consciousness and organization that are objectified in the sense that they are constituted externally to particular people and places” (p. 13). This perspective informs analysis of the way in which participants’ effort and attention are coordinated towards the organization’s mission as well as the way in which ruling takes place in routine practices, with ruling interests established as organizational interests through text-mediated decision making (DeVault & McCoy, 2012).

When discussing the application of IE to health professions education, and particularly medical education, Ng et al., (2017) suggest that IE is of particular use to understand how social relations could constrain everyday practices, or why participants in an organization could ‘fall through the cracks’ within and between systems. An understanding of how gaps arise between policy and practice provides an opportunity to identify a problematic and contributes to an empirical basis for social change (Ng et al., 2017). With its methodological approach and theoretical considerations, IE is compatible with structuration theory, which seeks to overcome the
theoretical divide between structural functionalism and symbolic interactionism that has characterized much of the initial sociological analysis of medical education research, especially with respect to professional socialization. IE understands work as people’s coordination of their performance in an environment that provides rules and expectations, and people’s engagement with and practices of these rules and expectations. Therefore, IE is also compatible with the community of practice theory, which underlines the significance of participation and interaction with others in coming to master a specialized body of work. With its emphasis on the impact of social relations and ruling relations on individuals’ experiences and its assumption that people are experts in their work, IE has the potential to trace the institutional nature of people’s everyday experiences. Utilizing the methodology of IE, I could provide both a detailed and systematic account of medical students’ learning experiences with professionalism and professional identity.

4.4 Data Collection

Modified according to Hafferty’s (1998) classification of curriculum in medical education, curriculum is operationalized in this study as consisting of three types: formal curriculum, informal curriculum, and hidden curriculum. With the intention of emphasizing the significance of text in coordinating people’s activities in institutions in IE projects, the formal curriculum is defined as the curriculum that is designed for the Doctor of Medicine (MD) program at the CoM and is put into documents – syllabi, learning objectives, and other documents that set the expectations for medical students’ knowledge, skills and competencies. The formal curriculum defines and provides the learning opportunities (e.g., the available courses and the pedagogy on a certain topic) in medical schools. Informal curriculum is the content that is actually delivered to medical students, which might be in accordance with or in contrast to the formal curriculum. Examining the informal curriculum could reveal the learning mechanisms in medical schools, especially in clerkship that is less structured and involves informal and self-directed learning. Texts that state clearly what medical educators are asked to teach can be interpreted by different medical educators in different ways. The guidelines on medical education, especially at an institutional level, change from year to year based on course evaluations and curriculum reviews conducted both internally and externally, so do the instructors responsible for teaching courses and sessions relevant to professionalism and professional identity. In other words, the informal curriculum is the operationalization of the formal curriculum and is the knowledge that is communicated to students for the purpose of teaching, which can happen in both classroom and clinical settings.

If the formal curriculum stands for what the medical school intends to teach, the informal curriculum is what medical educators actually teach. The hidden curriculum, on the other hand, cannot be clearly articulated. It is defined in this study as what medical students actually learn, in other words, medical students’ lived experiences with the formal and informal curricula. The ‘hidden’ feature of the hidden curriculum is especially emphasized with respect to how it is hidden not from students but from medical educators and medical schools. Confronted with various sources of knowledge, both technical and social, medical students make judgements on matters such as what aspects of knowledge and skills are required while others are optional, what
they should do to be successful in medical school, what medical professionalism means to them, and how they want to demonstrate it. This study intends to reveal the alignments and gaps not only between the formal curriculum and the informal curriculum, but also between the hidden curriculum, and the formal and informal curricula.

The theoretical framework and methodology of IE guide the data collection and analysis of this study. Three data collection methods are utilized for this study, including document collection, participant observation and in-depth interviews. Besides gathering documents that have open access on the CoM website, I conducted participant observation of relevant courses and interviewed medical students and faculty. The three data collection methods are described below in more detail.

4.4.1 Document collection

Texts play a significant role in IE analysis because of their ability to connect the local to the trans-local (Quinlan, 2009). According to Quinlan (2009), “Related to the concept of discourse, as defined by Foucault, texts shift the focus away from individuals towards the social organization of power” (p. 628). The replicable feature of texts allows different readers to read them across time and space, and have different interpretations while the texts remain constant (Quinlan, 2009). The constancy of texts contributes to an integral feature of institutions, the standardization of people’s actions. Texts are also implicated in the ruling relations because they stabilize and reproduce institutions (Quinlan, 2009). Document analysis in this study is utilized to collect data on the formal curriculum on professionalism and professional identity at this medical school. This analysis can help to reveal how texts – manifested in medical school as policies, forms, written protocols, syllabus, learning objectives and written communications – coordinate activities and experiences.

The CoM website is open to public access to the entire database of undergraduate curriculum, schedules and objectives, together with policies, procedures and forms for MD students. In this study, I reviewed the overall curriculum structure, together with syllabi of courses that are directly or indirectly relevant to professionalism and professional identity, including Clinical Integration I, II, III, IV; Clinical Skills I, II, III, IV; Medicine & Society (M&S) I, II, III, IV; Success in Medical School (SinMS) I, II, III; and Preparation for Residency. I also reviewed relevant policies, procedures, and forms that have professionalism in the titles and include the following: ethics and professionalism, professionalism flowchart, standard operating procedure – procedures for concerns with medical student professional behaviour, undergraduate medical education program informal discussion form, and undergraduate medical education program professionalism concern form – professionalism report form.

I also reviewed other policies, procedures and forms that do not have professionalism in the title but are relevant to professionalism and professional identity, including: clerkship electives policy, clerkship work hours and call policy, clinical reorientation formative assessment, dress code policy, group exam review guidelines, guidelines for students working part-time as health professionals, MD program clerkship attendance and absence policy overview, MD program pre-
Texts play an important role in guiding and coordinating both students’ and faculty’s behaviours. The policy documents were reviewed with specific attention to how professionalism is defined at the CoM and which aspects of professionalism are covered and emphasized in these documents. These texts are important not only in themselves, but also when compared to how these texts are interpreted and made relevant to medical students through the informal curriculum, and the impact these policies and interpretations have on students’ learning experiences and understanding of professionalism. The curriculum documents were reviewed to identify learning opportunities that are potentially relevant to students’ learning of professionalism and PIF and examine the expected learning outcomes. Similarly, these findings are equally important in themselves and when compared to the informal curriculum and students’ lived experiences to evaluate whether medical school is providing adequate learning opportunities to support students to meet the learning outcomes.

4.4.2 Participant Observation

Participant observation is another data collection method that is common in IE (Walby, 2013). Because IE proposes that everyday life is constituted by people whose activities are coordinated in certain ways, researchers need to capture detailed accounts of those activities (Campbell & Gregor, 2002). The participant observation in this study follows the guidelines of Campbell and Gregor’s (2002) suggestions on how to look and listen:

When institutional ethnographers conduct observations, besides making note of what is happening, they listen for the sort of informants’ talk that contains and expresses their expertise of living their lives. That way of talking – expressing one’s expertise of how to be a competent participant of a setting... (p. 69)

The method of participant observation is utilized as one way to reveal the informal curriculum at the CoM. The data on informal curriculum are gathered to understand how the formal curriculum is delivered in a classroom or clinical setting. Participant observation in this study was limited to cover classroom teaching. While the medical program also includes training in clinical settings, a decision was made that these parts of medical education were beyond the scope of a PhD project because different ethics consideration and approval protocols would have been required to conduct participant observation in clinical settings which involve the teaching hospital and patients. However, it is hoped that interviews with medical students and faculty, which are described below in the interviews section, would provide insights into the informal curriculum in clinical settings.
Two courses that are closely related to professionalism and professional identity and are established for the purpose of addressing these issues at the CoM are M&S, which is available to first- and second-year medical students, and SinMS, which is available to first-, second-, and third-year medical students. For example, SinMS I includes sessions on professionalism, policies and procedures, professionalism & social media, attendance policy and career advising & mentoring; and M&S I includes sessions on cultural safety and competency, Indigenous people and interprofessional practice. Both courses not only address professionalism issues at the policy level but also emphasize social dimensions of health, medical humanities, and the purpose of medicine as a profession in society, all of which contribute to students’ understanding of medical professionalism and their formation of a professional identity.

It is important to mention that the sessions in both courses change slightly from year to year, as do the course director(s), course chair(s), or instructors responsible for each session. The participant observation for this study was conducted during the fall term of 2017 and winter term of 2018 with the hope to cover one academic year of medical training. It is also worth mentioning that because of other responsibilities of being a PhD student and the overlap between sessions in M&S and SinMS in different years, I missed some of the sessions of the two courses; however, the key sessions related to professionalism and professional identity were observed and notes were taken.

The focus of participant observation is to reveal how the course objectives listed in the course syllabi are achieved in the classroom environment, the knowledge that medical educators transmit to medical students through examples provided and activities organized in class, and whether the modules and sessions in each course could together contribute to the overall course objectives. Information that I specifically looked for during participant observation includes instructors’ understanding of the medical profession, their interpretation of the expectations for medical students and their emphasis on certain types of knowledge. I paid close attention to not only instructor’s delivery of the course but also students’ responses to what is presented and activities that are asked of them in class.

4.4.3 In-depth Interviews

Smith (2005) places the subject at the center of the analysis in her approach to understand how everyday life is organized and ruled. The starting point of IE is personal experience. Doing IE means taking a particular stance towards the subject matter (Campbell & Gregor, 2002). Talking about entry points for investigation, Smith (2005) insists that a particular orientation of the researcher’s interest and attention should be the start for the investigation of the everyday world. Two of IE’s concepts – standpoint and problematic – are important here. Smith (1987) uses the concept of problematic “to direct attention to a possible set of questions that may not have been posed or a set of puzzles that do not yet exist in the form of puzzles but are ‘latent’ in the actualities of the experienced world” (p. 91). It allows IE researchers to disrupt the taken-for-granted and “take the everyday world as an unfinished arena of discovery in which the lines of social relations are present to be explored beyond it” (p. 39). This study views curriculum not as a finished product of content delivered but a fluid process that can be formal, informal, or hidden.
that happens in a community and forms social relations and seeks to dissect the taken-for-granted knowledge and practice in medical school, which is the problematic of this study.

Standpoint, as an approach, “works from the actualities of people’s everyday lives and experience to discover the social as it extends beyond experience” (Smith, 2005, p. 10). Standpoint recognizes that people are experts about their lives and their work. The expertise that people have – them explaining what they know about what they do – is the entry point that allows researchers to reveal the social conditions that people navigate (Miller, 2015). When interviewing, the focus is not to reveal subjective states but to trace the connections among individuals with different status and working in different parts of the institutional complexity (DeVault & McCoy, 2012). The objective of this study is to review the three types of curricula on professionalism and professional identity to understand the complicated process of how medical students learn professionalism and develop professional identities. Though both students and faculty were interviewed and the institutional practices that provide learning opportunities and learning mechanisms were analyzed, this study takes the standpoint of medical students. It puts medical students’ experiences at the focal point of this study and aims to improve their learning experiences with professionalism and professional identity by proposing changes at both individual and institutional levels.

Participants who engaged in the in-depth interviews in this study include medical students and faculty. Even though this study takes the standpoint of medical students, the perspectives of faculty members, especially those who are in leadership roles, have administrative responsibility, or teach courses relevant to professionalism and professional identity, are also sought to understand the rationale of medical school’s practice. The working experiences of faculty is also crucial to understand students’ learning experiences as the latter largely depend on faculty being role models and mentors.

The undergraduate medical education program (UGME) at the CoM is a four-year program and is divided into two years of pre-clerkship training, followed by two years of clerkship training. In the first year of pre-clerkship, students are expected to “gain a solid basis in preparatory clinical medicine and biomedical sciences, while developing clinical skills” (CoM, 2021). During the second year of pre-clerkship, students “will build on the foundations of clinical medicine, professional and clinical skills” and “will participate in flipped classrooms, case-based learning, and develop clinical reasoning skills” (CoM, 2021). In clerkship, students learn through participating in core rotations, electives, and selectives, which “are supplemented with seminar-style classes that provide opportunities to apply the knowledge, skills, and attitudes students have acquired and use them when interacting with patients in the medical environment” (CoM, 2021).

Medical students who are interviewed in this study include both pre-clerkship students and clerkship students. Most of the questions asked during the interviews are broad, general, and open-ended and allow interviewees to provide their own accounts of teaching and learning experiences in medical school. Questions for medical students focus on their perceptions of being medical students and future physicians, their learning experiences of professionalism, and the
circumstances and influential players that contribute to their transition from layperson to insider. Questions for faculty focus on their teaching experiences in relation to professionalism and professional identity and their understanding of these learning objectives.

Sixteen medical students participated in the in-depth interviews for this study, conducted between May 2017 and June 2018. Five of them were interviewed in their first-year of medical school (four female and one male); four of them were interviewed in their second-year of medical school (three female and one male); three were interviewed in their third-year of study (two female and one male); another three were interviewed in their fourth-year of study (one female and two male); and one male medical student was interviewed twice, the first time in second-year and the second time in third-year. The average length of the interviews was 79 minutes. Ten faculty (six male and four female) also participated in the in-depth interviews. Seven of them have been involved with the course of M&S and/or SinMS, though at different times. The average length of the interviews was 74 minutes. All interviews (except one in which notes were taken) were recorded and transcribed for analysis.

The formal, informal, and hidden curricula are interrelated and cannot be completely separated. To take advantage of this character of the curriculum under the methodology of IE, the three methods of data collection were started around the same time so that they could provide a complete picture of the curriculum being investigated. For example, knowledge gained from the individual interviews with medical students pointed to new directions for participant observation and document collection, and information acquired from the participant observation helped to modify the questions for individual interviews. As data, any of the key concepts, including curriculum components, extracurricular activities, and groups of participants at the CoM are treated as the next steps in the inquiry. They might have suggested people who might know important things about the process of medical training or key events that might make an impact on medical students’ learning of professionalism and PIF. There was no pre-determined number of interviews to be conducted and the process of data collection was ongoing until it reached the methodological principle of saturation (Glaser & Strauss, 1967; Sauunders et al., 2018) where no new curriculum component, event or stakeholder that are relevant could be revealed.

4.5 Data Analysis

When discussing the process of conducting IE research, DeVault and McCoy (2002) emphasize the open-ended nature of IE inquiry:

There is no ‘one way’ to conduct an IE investigation; rather, there is an analytic project that can be realized in diverse ways. IE investigations are rarely planned out fully in advance... Instead, the process of inquiry is rather like grabbing a ball of string, finding a thread, and then pulling it out; that is why it is difficult to specify in advance exactly what the research will consist of. (p. 755)

This is true not only for data collection of IE, but also data analysis. For this study, one of the common qualitative data analysis approaches, thematic analysis, together with a significant
concept of discourse, are accompanied by the mapping of data, which is a unique approach of IE to achieve the theoretical and empirical objectives of this study.

4.5.1 Thematic analysis

Thematic analysis is a data analysis method for “identifying, analyzing and reporting patterns (themes) with data” (Braun & Clarke, p. 79). Coding or identifying themes is not commonly used and is sometimes even discouraged in IE with the concern that it might distort or obscure the relations that IE seeks to expose (Campbell & Gregor, 2002). However, DeVault and McCoy (2002) argue that software that supports qualitative data analysis could be used in IE to group chunks of transcripts by theme or topic. DeVault and McCoy (2002) further explain that this method works best if the grouping is done rather simply – like the indexing for a book – and the researchers stick closely to “topics of talk and references to institutional sites and process” (p. 769). This approach to sorting the data, which is aided by qualitative analysis software, works at the primary level and offers researchers a manageable way to get started with large numbers of interviews and field notes, while at the same time leaving the analytic work to be done by researchers (DeVault & McCoy, 2002).

This study is a unique IE project in the sense that even though the formal curriculum, which is manifested in texts, accounts for a significant percentage of the data, so is the informal curriculum and hidden curriculum, which are not in text format. In other words, informants’ activities are coordinated not only by texts, but also by knowledge or rules that are informal or difficult to articulate. As two of the empirical objectives of this study are first, to reveal the gaps between the formal curriculum and the informal and hidden curricula and second, to explore the relationship between learning professionalism and developing professional identities, grouping of the data is necessary at the beginning of the process of data analysis. Because this study gathers a large amount of data, thematic analysis is used in the first round of analysis with the support of NVivo to identify and track important occasions, events, and informants, and locate information on the three types of curricula and two of the studied topics. Even though a thematic analysis is conducted, data are not categorized in ways that are artificial; rather the meaning of the data, which is in their setting of use, is explored. In IE, informants are not expected to have similar experiences, so differences are also accounted for in the analysis (Campbell & Gregor, 2002). Through uncovering the social relations that organize informants’ experiences, researchers seek to have a better overall understanding of what is happening and discover coherence (Campbell & Gregor, 2002). According to Campbell and Gregor (2002), “Generalizability in IE relies on discovery and demonstration of how ruling relations exist in and across many local settings, organizing the experiences informants talked about” (p. 89).

4.5.2 The concept of discourse in IE

Professionalism and professional identities are becoming two popular discourses in medical education literature (Sullivan, 2016). Even though this study does not conduct a discourse analysis, the concept of discourse, which is significant to qualitative research and IE, warrants
some discussion here. Discourse, as an organizer of experience, is an enacted feature of social organization (Campbell & Gregor, 2002). In discussing Smith’s notion of discourse, DeVault & McCoy (2002) comment:

For Smith, discourse refers to a field of relations that includes not only texts and their intertextual conversation, but the activities of people in actual sites who produce them and use them and take up the conceptual frames they circulate. This notion of discourse never loses the presence of the subject who activates the text in any local moments of its use. (p. 772)

IE studies contemporary social organization to explicate ruling relations through text-based discourses and objectified forms of knowledge (Campbell & Gregor, 2002). Professionalism and professional identity, as two topics of this study in medical education, are analyzed through this approach of understanding discourse. The goals are to reveal how these discourses are constructed and defined at this medical school through individual actions and institutional practices and how they are present in different types of curricula to impact medical students’ learning experiences with them.

4.5.3 Mapping social relations and social organization of learning environment

To conduct IE, it is important to be attentive to recognize that a person can speak about his or her life while remaining unaware of its social organization (Campbell & Gregor, 2002). Individuals are not fully aware of how their daily activities are linked to the work of others, which could be said of both the medical students and faculty working at a particular medical school (Ng et al., 2017). According to Campbell and Gregor (2002), “Social life has crucial meanings organized outside local settings where people live and from which they speak when they talk about their experiences” (p. 91). This discursively organized feature of social life requires researchers to discover and disclose social organization and how the taken-for-granted knowledge is meaningful for what happens to people working in the social organization. Through tracing what people do, it is possible for IE research to identify the connections between people of different status in an institution or connections between people and policies.

Therefore, data gathered from the three methods are also mapped to understand the social organization of people’s lived experiences. The inclusion of multiple informants and data sources makes it possible to examine a range of angles, through which we can explicate people’s everyday activities (Ng et al., 2017). This mapping approach is guided by a question asked by Campbell and Gregor (2002): “What does it tell me about how this setting or event happens as it does” (p. 85) and a question asked by DeVault and McCoy (2002): “How is it that these people are saying what they are saying” (p. 769). According to Smith (2005):

The aim of the sociology we call ‘IE’ is to reorganize the social relations of knowledge of the social so that people can take that knowledge up as an extension of our ordinary knowledge of the local actualities of our lives...mapping the relations that connect one local site to others. (p. 29)
This study is ultimately an IE of the curriculum on professionalism and professional identity and, therefore, data are mapped in ways that can contribute to the understanding of either professionalism or professional identity. Because one of the goals of this study is to analyze the alignments and gaps between the different types of curricula, data are also mapped so that they provide information on how the formal curriculum is structured, how the informal curriculum is delivered, and how students experience the curriculum. In addition to presenting thematic analysis results, the mapping approach specifically focuses on drawing connections across courses or learning modules. It helps explain how the formal curriculum presented by, and informal curriculum delivered by, the CoM give an institutional nature to the construction of the concept of professionalism, and students’ learning experiences of professionalism and PIF. Mapping also helps reveal social relations, which relies on learning together for the community of medical students in pre-clerkship and working together for the community of medical practice in clerkship, and how these social relations directly impact students’ learning experiences. The analytic approach of mapping, which is unique to IE, informs the identification of the contributors and barriers to medical students’ learning of professionalism and PIF, and changes proposed to support these two learning objectives in medical education.

4.6 Methodology summary

IE is utilized in this study as the overall methodology to explore how medical students learn professionalism and develop professional identities, and more importantly, why their learning experiences with these topics are what they are. Their actions and lived experiences are analyzed to pose questions about and address the institutional practice on the teaching and learning of professionalism and professional identity, and ruling relations in medical school. Ruling processes cannot be easily understood from excluded perspectives of any local experience but are instead pervasive and consequential. Building upon the actualities of work of medical students and faculty, I map the institutional processes through revealing the different types of curricula that are fully embedded in the institution of medical school and propose changes that could improve the learning experiences of medical students.

Following the approach of IE, the next two chapters describe the current conditions surrounding the teaching and learning of professionalism and professional identities at the CoM. For the chapter on findings in pre-clerkship, the mapping will be divided into the formal curriculum, the informal curriculum, and the hidden curriculum. The pre-clerkship chapter will also address the social relations that coordinate medical students’ school and social life, which contribute to the construction of a medical student identity. For findings in clerkship, the mapping would identify the formal curriculum, the learning mechanisms in clerkship, and the impact of learning on students’ development of professionalism and PIF. The clerkship chapter also specifically describes PIF as a distinctive goal of medical education and the key features of PIF as a social practice.
CHAPTER 5 FINDINGS PART 1 – LEARNING PROFESSIONALISM AND TRANSITIONING TO MEDICAL STUDENT IDENTITY IN PRE-CLERKSHIP

5.1 Introduction

This chapter presents findings on pre-clerkship learning opportunities that are relevant to professionalism and the transition to medical student identity in pre-clerkship when students hold the primary identity of a learner. In the first section of learning professionalism in pre-clerkship, I will address students’ learning of three types of professionalism, highlighting the socially constructed nature of the concept of professionalism and the impact of explicit and tacit expectations in guiding students’ management of their time and learning. The learning on professionalism is mapped into the formal curriculum, the informal curriculum, and the hidden curriculum to identify any gap between the three types of curricula. In 5.2.1, major parts of the overall map of students’ learning of professionalism and PIF, including CoM’s statements, policies, and procedures on professionalism, CoM’s approaches on regulating professionalism concerns, and medical students’ lived experiences with the professionalism policy, are discussed. In 5.2.2, courses and experiential learning opportunities that allow students to explore medical professionalism and physician roles, along with how these learning opportunities are delivered and how medical students experience them, are added to the overall map. The two sections together outline how medical students learn and internalize professionalism in pre-clerkship at the CoM.

In the second section of transitioning to medical student identity, I will discuss the distinct identity of medical students, and how medical students adjust and transition to this new identity. In this section, I emphasize the impact of the community of learning in pre-clerkship on students’ construction of an identity that is medicine-driven. As there is no structured curriculum on the medical student identity, the second section, which maps the first step of medical students’ PIF, is organized according to themes instead of different types of curricula. It outlines students’ expectations for medical school, the cohort impact, the expectations from medical school, and students’ primary learner identity as major parts of the overall map of professionalism and professional identity in medical education.

5.2 Learning professionalism in pre-clerkship

Students are introduced to the concept of professionalism at the very beginning of medical school; but more importantly, they are introduced to a professionalism that is defined by the CoM. Three types of professionalism are identified in medical students’ learning experiences in pre-clerkship. These are student professionalism, professionalism in professionals, and medical professionalism. This section will first address student professionalism and professionalism in professionals, as these two types are closely connected in not only the formal curriculum but also the informal curriculum. This section will then describe the learning opportunities on medical professionalism and physician roles in pre-clerkship and medical students’ experiences with them,
even though these learning opportunities currently are not put under the overarching theme of professionalism.

The CoM provides an institutional definition of professionalism that represents student professionalism and professionalism in professionals through defining professionalism with references to examples that focus on student professionalism and professionalism in professionals. This is practiced in not only written policies but also professionalism lectures, especially during orientation to medical school. These teaching and administrative approaches are further established as institutional practices on professionalism issues. At the same time, the other important dimension of professionalism, the medical professionalism, simply exists in college statements without exerting meaningful impact on teaching practices or learning experiences. By learning and internalizing both the explicit and tacit expectations, students understand the aspects of professionalism that are monitored and evaluated by the CoM have more direct and immediate relevance to their learning and evaluation, and respond accordingly. The gaps between how expectations are preached and how students see faculty behave further contribute to students’ cynicism and disengagement from professionalism issues. The CoM’s institutional practice of teaching professionalism through policy forms fails to acknowledge the impact of learning environment or the knowledgeability of medical students. Medical students mainly learn professionalism through learning not to be unprofessional in pre-clerkship because of such institutional practice.

Many important dimensions of medical professionalism are indeed included in M&S courses, and patient-centred care and interprofessional practices are particularly emphasized in experiential learning. These learning activities rarely refer to the concept of professionalism but are generally linked to the framework of physician roles instead. Though the content is explicitly presented, the tacit knowledge, exemplified by the limited time dedicated to M&S courses and experiential learning, and the evaluation of students that focuses on knowing instead of doing, make it difficult for students to see the relevance of non-medical expert roles or value the M&S courses. In the following sections, I elaborate on the above key findings in more detail.

5.2.1 Student professionalism and professionalism in professionals

Student professionalism is defined in the analysis as the type of professionalism that is universal to students and not unique to medical students. Professionalism in professionals is defined as the type of professionalism associated with transition into a professional occupation or role in the sense that “because you are a professional, you need to demonstrate professionalism and certain behaviours”. These two types of professionalism account for a large proportion of discussion on professionalism at the CoM, especially in pre-clerkship. They are very present in the CoM’s statements, policies, and procedures regarding professionalism, ‘professionalism talks’ to medical students, and how policies and procedures are implemented in practice. This section will address the formal curriculum, informal curriculum, and hidden curriculum in relevance to student professionalism and professionalism in professionals at the CoM.
5.2.1.1 Formal curriculum

A great extent of the teaching of professionalism at the CoM is done through referring to it in specific policies, the approach of which has generated various responses and comments from faculty and students. The majority of participants interviewed agreed that most of the teaching of professionalism through identifying and explaining professionalism policies can be considered as the student professionalism or professionalism in professionals. Many would like more discussion around medical professionalism in the curriculum through various pedagogies, such as experiential learning or service learning. This section of the formal curriculum presents the CoM’s statements with reference to professionalism and professionals, policies and procedures, and module of Orientation and Professionalism with the objective to introduce students to the concept of professionalism.

5.2.1.1.1 Statements – ideals of professionalism and a clear pathway

The importance of the topic of professionalism and professionals at the CoM is first and foremost made explicit in the CoM’s official statement. The document *Ethics and Professionalism (Appendix A)* is a combination of several statements with reference to professionalism. However, the CoM does not provide any overall rationale for the existence of the document and the document is divided into four separate sections without drawing any connections between them.

The first section is the CoM’s statement on professionalism, which is original and is dated to 2005. The statement states that:

We, as teachers, learners and educational support personnel of the College of Medicine, University of Saskatchewan have a responsibility to ourselves as individuals, to each other, and to patients and society as a whole, to understand and exhibit the highest standards of personal, interpersonal, and public professionalism.

The three levels of professionalism (personal, interpersonal, and public) are further explained in more detail in the statement:

1. As individuals, we commit to demonstrating the personal characteristics necessary for moral function within the medical profession and the university community, and as representatives of these occupations within society as a whole. Such characteristics will include but are not limited to humility, respect for others, and self-care.
2. As caregivers, colleagues and coworkers, we will demonstrate professional interpersonal behaviour in all settings, guided by the values of integrity, accountability, and responsibility.
3. As medical professionals, learners, and educational support personnel interacting in the public domain, we will strive to fulfill all reasonable health-related societal expectations, demonstrating at all times compassion, reliability, honesty, respect, and an appropriate level of competence. We will seek to promote the public good and understand the principles of good stewardship. We will adhere to the Codes of Ethics of our professions and occupations.
The statement states that the CoM “will treat any significant divergence as a serious threat to the mission and values of the College of Medicine”.

The second section in the *Ethics and Professionalism* document is the CoM’s guiding principles of professionalism, which is used with permission from Dalhousie University Faculty of Medicine’s “Dalhousie Medical School Professionalism Committee Professionalism Policy”. It lists four principles:

- **Respect for others**: professionals demonstrate consideration and respect for others including patients, their families and support persons, colleagues, classmates, teachers, other professionals and the public.
- **Honesty and integrity**: professionals demonstrate adherence to the highest standards of personal, professional and academic honesty and integrity.
- **Compassion and empathy**: professionals demonstrate compassion and empathy for those in distress and especially for patients, their families and support persons.
- **Duty and responsibility**: professionals acknowledge their duties to patients, their profession and society and accept the responsibilities that flow from these duties.

Each of these principles and descriptions is further accompanied by bullet-form detailed explanations.

The third section is entitled the *Canadian Medical Association (CMA) Code of Ethics*. The title is followed by “Updated 2004; reviewed March 2015” and a web link that is no longer functional. The CMA had updated its *Code of Ethics* to *CMA Code of Ethics and Professionalism (the Code, Appendix B)*, which was approved by the CMA Board of Directors in December 2018. The content in the *Ethics and Professionalism* document is therefore outdated. The new Code “articulates the ethical and professional commitments and responsibilities of the medical profession”, and states: “In this Code, medical ethics concerns the virtues, values, and principles that should guide the medical profession, while professionalism is the embodiment or enactment of responsibilities arising from those norms through standards, competencies, and behaviours.” The first part of *The Code*, which describes virtues exemplified by the ethical physician, states:

- **Trust** is the cornerstone of the patient–physician relationship and of medical professionalism. Trust is therefore central to providing the highest standard of care and to the ethical practice of medicine. Physicians enhance trustworthiness in the profession by striving to uphold the following interdependent virtues: compassion, honesty, humility, integrity, and prudence.

The second part outlines the fundamental commitments of the medical profession: commitment to the well-being of the patient; commitment to respect for persons; commitment to justice; commitment to professional integrity and competence; commitment to professional excellence; commitment to self-care and peer support; commitment to inquiry and reflection. The last part describes professional responsibilities, which is further divided into: physicians and patients (patient–physician relationship and decision-making), physicians and the practice of medicine (patient privacy and the duty of confidentiality, and managing and minimizing conflicts of interest), physicians and self, physicians and colleagues, and physicians and society.
The fourth section is the Student Oath of Commitment, which is modified from the University of Kansas School of Medicine Oath of Commitment and declared by students during the White Coat Ceremony, which happens at the beginning of Year 1. One item from the Oath that has professionalism in it is: “I will adhere to the standards of professionalism as specified by the college, such that my conduct upholds and reflects the high calling of my profession.” However, the rest of the items in the Oath can all be traced to The Code even though the word ‘professionalism’ is not in them.

Besides the CoM’s professionalism statement, in the CoM’s MD Program Learning Objectives (Appendix C), becoming a professional is identified as one of the seven learning objectives together with: medical expert, communicator, collaborator, leader, health advocate, and scholar. The description of the ‘professional’ as a learning objective is as follows:

The graduating physician accepts the tenets of the profession: commitment to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high standards of personal behavior. Physicians are guided by codes of ethics, committed to clinical excellence, and embrace appropriate attitudes and behaviors, including honesty, altruism, integrity, commitment, compassion, respect, and the promotion of the public good.

- Demonstrate professional behavior informed by ethical/legal standards and awareness of personal wellness and limitations.
- Describe current ethical and legal principles important in medicine including those related to informed consent, capacity, patient autonomy, privacy and confidentiality.
- Explain the evolving contract between physicians, their organizations and society.
- Demonstrate culturally safe and respectful care of all patients including First Nations, Inuit, and Metis.

The content listed in the above statements focuses heavily on medical professionalism, the aspects of professionalism that are fundamental to the establishment and development of the medical profession, and the evolving contract between medicine and society. The content in the professionalism statements addresses the medical professionalism at an individual level (such as qualities of honesty and integrity), interpersonal level (such as qualities of respect and compassion), and societal level (including accountability, promotion of public goods, the evolving contract between physicians and society, and other commitments). The content includes expectations with regards to both behaviours (like informed consent, and privacy and confidentiality) and motivation (such as the high calling of the medical profession).

These statements describe the ideals of medical professionalism and draw a clear pathway with detailed actionable behaviours for medical students to follow. They are, however, introduced in this section of student professionalism and professionalism in professionals because they are included as a part of the package of policies and procedures (discussed in 5.2.1.1.2) handed out to students at the beginning of medical school. The time spent in describing these statements is also significantly less than the time allocated to explaining the CoM’s professionalism policies and procedures. I have provided the context in this section of how professionalism is defined in the CoM’s statements on professionalism. The functions of these statements are made explicit when
comparing them to how professionalism is defined in CoM’s professionalism policies and procedures, how they are interpreted to students, and how they are implemented.

5.2.1.1.2 Policies and procedures – the CoM’s professionalism policy

While the above mentioned CoM’s statements on professionalism draw upon information from other medical schools and the national medical association – CMA – the CoM has developed its own “professionalism policy” (according to the CoM’s website) – Standard Operating Procedure- Undergraduate Medical Education: Procedure for Concerns with Medical Student Professional Behaviour (SOP, Appendix D). It outlines the “processes for responding to concerns of lapses in professional behaviour by medical students”. This main policy is accompanied by the following documents: Undergraduate Medical Education Program Informal Discussion Form (Appendix E), Undergraduate Medical Education Program Professionalism Concern Form (Appendix F), and three flowcharts on Procedures for Concerns with Medical Student Professional Behaviour (Appendix G).

The CoM’s professionalism policy was made effective in July 2017 with a review date July 2019, which is the current available version on the CoM website. According to the SOP:

The purpose of the Procedures for Concerns with Medical Student Professional Behaviour is to articulate the implementation of the Regulations on Student Academic Misconduct and Standard of Student Conduct in Non-Academic Matters and Regulations and Procedures for Resolution of Complaints and Appeals within the College of Medicine.

The two Regulations are UofS’s policies on academic and non-academic misconduct. According to the University’s websites that describe the two Regulations: “Academic Misconduct is the term the university uses to describe cheating” and “The university Standard of Student Conduct contains a set of principles and expectations that are intended to govern student conduct”.

The SOP is intended to provide “transparent processes for responding to concerns of lapses in professional behavior by medical students”. The SOP ensures that “the Undergraduate Medical Education program meets or exceeds the following Committee on Accreditation of Canadian Medical Schools accreditation standards:

3.5 Learning Environment/Professionalism: A medical school ensures that the learning environment of its medical education program is conducive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations and is one in which all individuals are treated with respect. The medical school and its clinical affiliates share the responsibility for periodic evaluation of the learning environment in order to identify positive and negative influences on the maintenance of professional standards, implement appropriate strategies to enhance positive and mitigate negative influences, and identify and promptly correct violations of professional standards.

It is also stated in the SOP that:
It is the expectation that medical students as junior colleagues and members of the medical profession are held accountable to the same standards as professionals in the medical field... Specifically both medical students and clinical faculty will be expected to adhere to the same principles of professionalism.

The formal curriculum has demonstrated that the CoM intends to ensure that the learning environment is conducive to support students’ development of professionalism and students and faculty are held equally accountable on professionalism issues. However, the interactions between faculty and students and students’ reflection on their experiences run counter to this ideal and reveal a very unbalanced power relation.

Even though it is stated that the SOP is “informed by the...guiding principles” in the Ethics and Professionism document, which describes the desired professional behaviours or qualities, the main content in the SOP defines and gives examples of unprofessional behaviours. Unprofessional behaviours are categorized into three types: minor incident, which is an incident that has minimal consequence; major incident, which is an incident that has the potential for serious consequences; and critical incident, which is an incident that has direct harmful consequences or is an egregious breach of well-recognized standards. I provide here some of the examples of minor incident (see Appendix D for the full lists of examples provided by the college):

- Submitting an assignment late
- Arriving late for a mandatory lecture or clinical learning experience
- Missing a mandatory
- Presenting an appearance that may not be perceived by patients as professional
- Using language in email, assignment or other communication that may be overly casual or may be perceived as otherwise inappropriate or disrespectful

When an incident of unprofessional behavior is reported, depending on the nature of the incident (minor, major, or critical) and, if minor incident, the number of occurrences, the student being reported will meet with either the reporter, Year Chair, or Associate Dean, to complete either the Informal Discussion Form or Professionalism Concern Form or a formal complaint to the UofS. See Appendix G for detailed procedures for minor incident (including first occurrence, and multiple, and subsequent occurrences), major incident, and critical incident respectively.

A wide divergence can be observed between what are included here as examples of breach of professionalism and the content of the CoM’s professionalism statements. The first three examples (submitting an assignment late, arriving late for or missing a mandatory) describe breach of student professionalism while the last two examples describe breach of professionalism that professionals demonstrate. These expectations are not unique to medical students or medical professionals. The way professionalism is defined through texts and interpreted by the CoM, and how the incidents of unprofessional behaviours are handled by the CoM, are particularly relevant for students’ lived experiences with the learning of professionalism and their overall learning experiences as medical students at the CoM. This relevance will be further discussed in the sections on informal and hidden curricula.
Professionalism is emphasized in the continuous evaluation of medical students at the CoM. It is stated in the SOP:

In the teaching and learning of Medicine, professionalism is a core academic competency and is continuously being assessed throughout the undergraduate medical education program. Clinical courses include professionalism as a component to be taught and assessed. These procedures are not intended to override course-related assessment processes or documentation. The primary intention of these procedures is to provide an effective mechanism for the early identification of students who need assistance with their professional development so that appropriate remediation can be implemented in support of their successful completion of the program. They should be considered when unprofessional conduct is identified that is outside the developmental norms for a student’s cohort. The secondary intention of these procedures is to assist with crucial academic decisions when remediation is unsuccessful or inappropriate.

It is reflected here that professionalism is not only seen as a developmental process to support students’ learning but also an evaluation standard and a means of discipline that could potentially have academic consequences. Even though the SOP and its associated documents are the main texts to communicate to students the CoM’s emphasis on professionalism concerns, professionalism has a consistent presence across the CoM’s other policies and procedures, and course policies in the course syllabi. Professionalism is listed as an overarching evaluation criterion that covers both academic and non-academic conducts, as illustrated in some examples that follow. The listed examples include policies and procedures for clerkship years and courses, as the content on professionalism policies and procedures is consistent in pre-clerkship and clerkship years.

The following message is found on the CoM’s ethics and professionalism website:

Note that breaches of professionalism that are egregious and/or refractory to correction may, in themselves and at the discretion of the Undergraduate Medical Education Committee, constitute sufficient grounds for removal from the program, regardless of performance in other aspects of the curriculum.

In the Undergraduate Medical Education Assignment Submission Policy (Appendix H), it is stated within the section on ‘principles’ that: “It is the expectation that all assignments will be submitted on time, as this is an element of professionalism”. In the detailed explanation of the policy, it is also stated that: “…students submitting mandatory assignments late should anticipate a meeting to discuss professionalism, which may result in associated documentation”.

In the MD Program Pre-Clerkship Attendance and Absence Policy Overview (Appendix I.1) and MD Program Clerkship Attendance and Absence Policy Overview (Appendix I.2), it is stated that:

Failure to abide by these regulations without appropriate prior approval or notice after the fact for emergent absences, or disregarding the program decision in relation to an absence request, will be deemed as a professionalism concern...Student who neglect their academic responsibilities may have academic consequences and this behaviour will also
be addressed through the *Procedures for Concerns with Medical Student Professional Behaviour*.

Within the ‘principles’ section of both policies, the CoM provides a rationale for the existence and implementation of the policies:

The College of Medicine recognizes that medical students are adult learners and entitled to the privileges and responsibilities that come with such status. That being said, for many components of the program, the College of Medicine relies heavily upon faculty with clinical obligations, their patients and other patient volunteers. Absenteeism and lack of punctuality by students place an unwelcome strain on the goodwill of all concerned... Acceptance of responsibility for attendance and participation in patient care is part of the student’s professional education and responsibility. Appropriate attendance and punctuality are indicative of the students’ understanding of, and adherence to, expectations of professional behaviour.

It has been the College’s experience that, for some students, chronic non-attendance often ends up in academic and/or professional difficulty. Students also end up feeling disengaged and separated from their class cohort, which can further affect academic success because of a lack of peer support. The College reserves the right to mandate attendance by those students who are in academic or professional difficulty.

Throughout these documents, certain behaviours (e.g., submission of assignments on time, attendance, and participation) are reinforced as aspects of professionalism that are monitored and evaluated by the CoM and, as will be discussed later, become important aspects of professionalism for students to watch for.

Course policies with relevance to professionalism are also consistently included in the course syllabi. For example, in the course syllabi of *SinMS* series, within the ‘course policy for successful completion and remediation’ section, it is stated that: “Students who do not attend and participate as expected in the course may fail the course on the basis of professionalism”. ‘Professionalism’ is also listed as a separate section in the course syllabi. In this section, similar content is listed again:

Students can be deemed unsuccessful on any course assessment for not achieving course expectations of professionalism. This would include, but is not limited to, any unapproved absences from a mandatory session, and/or submission of late assignment. Students failing to meet professional expectations in the course should anticipate a meeting with the Module/Course Directors and/or Year Chair to discuss the concern, which may result in associated documentation.

For *SinMS III* (for third-year medical students), professionalism is added as a specific criterion for evaluating students’ performance in clerkship: “The students will be given formative assessments on all clinical and procedural skills. Professionalism will be a component of assessment in this course”. Course policy also indicates that: “For successful course completion for the purposes of promotion, a student must complete all mandatory course components and demonstrate satisfactory attendance and participation, including ‘Meets Expectations’ on Professionalism”.

69
The policies on late assignment and attendance and the listing of ‘professionalism’ as a separate section are consistent across all course syllabi, with slight variation on which example of professionalism is emphasized. For science courses *Principles of Biomedical Sciences*, and *Foundations in Clinical Medicine* series (I, II, and III), the focus is on late assignments: “…students submitting mandatory assignments late should anticipate a meeting to discuss professionalism, which may result in associated documentation”. For *Medicine and Society* series, besides the focus on late assignments, professionalism is also discussed with regards to attendance for mandatory sessions: “Students who miss a mandatory session without prior approval or following appropriate notification steps in the event of illness should anticipate a meeting to discuss professionalism”. These practices of emphasizing professionalism and listing it as a separate evaluation component in course syllabi are also consistent for courses *Clinical Skills I, II, III, IV*, and *Clinical Integration I, II, III, IV*. For example, it is stated in the *Clinical Skills I* syllabus that:

Students should be aware that professionalism is being assessed in every Clinical Skills I session. Lateness or absences without appropriate notification/approval will likely result in marks reduced for poor professional behaviour and may result in an informal or formal breach of professionalism report. Unapproved absences may result in failure of a module or the entire course.

Even in *Clinical Skills* course series that cover communication skills, and effective and caring relationships with patients, professionalism is still defined in the syllabi with reference to lateness or unapproved absences. The consistent definition of professionalism with reference to certain professional behaviours becomes an institutional standard practice across different courses and different years in training and, as will be discussed later, has a long-term impact on students’ learning.

I have presented in this section the CoM’s policies and procedures on professionalism, including the CoM’s professionalism policy, other policies with professionalism component, and course policies that consistently address professionalism in course syllabi. In all these policies and procedures, professionalism is never clearly defined. In the professionalism policy, unprofessional examples are given mostly on student professionalism and professionalism in professionals, with a few unprofessional examples given with specific reference to patient confidentiality, and communication with patients and colleagues. Professionalism is also explained with references only to submitting assignments late or not attending mandatory sessions in other policies with professionalism component and course syllabi that consistently address professionalism. In these policies and procedures, the concept of professionalism is defined in relationship to two professional behaviours: submitting an assignment on time and attending a mandatory lecture. These policies and procedures represent particular forms of rules and provide guidelines that not only frame the structure of medical education but also guide faculty’s and students’ daily activities. This narrowing down of the concept of professionalism is furthered enhanced in the ‘Orientation and Professionalism’ modules when these policies and procedures are introduced and explained to medical students at the beginning of each year during orientation.
5.2.1.3 ‘Orientation and Professionalism’ module – introduction to the concept of professionalism

This section describes the formal curriculum in the MD curriculum structure that is dedicated to introducing students to the concept of professionalism. The teaching and learning of student professionalism and professionalism in professionals start from the beginning of medical school, during orientation. It is stated in the SOP that:

The College of Medicine will communicate the Procedure for Concern with Medical Student Professional Behaviour to faculty, staff, and students by ensuring that up-to-date versions of this procedure is publically available on the college website... Furthermore, the Undergraduate Medical Education Office shall further communicate this procedure by providing a written copy of this document to medical students in their first-year orientation package.

Medical students are made aware of the SOP not only in written forms but also through lectures during orientation. ‘Orientation and Professionalism’ is one of the modules of SinMS I (for Year 1 medical students) and is repeated for SinMS II (for Year 2 medical students) and SinMS III (for Year 3 medical students) with slight changes on specific sessions.

The purpose of the series of SinMS is to “provide students with information, experiences, and tools that will help them to be successful in all aspects of medical school from a personal, academic, and professional perspective” (SinMS I and II course syllabi) with the last one in the series specifically designed to “bridge between the first two years of the program and the clerkship years” (SinMS III course syllabus). Within the SinMS series, according to the syllabi, the purpose of ‘Orientation and Professionalism’ module is to:

provide students with general orientation to the College of Medicine program, the key administrative and support structures, and people within it. It will provide specific orientation to the policies and procedures relevant to the Undergraduate Medical Program. Additionally, this module will also introduce students to the concept of professionalism, which is a key concept in professional identity formation.

The specific sessions in the module ‘Orientation and Professionalism’ for SinMS I that are dedicated to professionalism issues include: professionalism & social media, professionalism, policies, & procedures, and party like a pro. For SinMS II, those sessions include: SMSS (Student Medical Society of Saskatchewan) professionalism talk, and professionalism and UGME policies and procedures. Professionalism, policies and procedures in clerkship is the professionalism session for SinMS III.

The ‘Orientation and Professionalism’ module, which has a focus on policies and procedures, is one of the three places where professionalism is present in the title of a course or the title of a session within a course in the CoM’s MD curriculum structure. The only other two places are a 50-minute session that covers all the following topics: truth-telling, research ethics, medical professionalism, and conflict of interest, which is the second session on ethics in Clinical Integration I; and social media & professionalism, which is a 50-minute session in M&S IV. The
module’s focus on policies and procedures can be reflected in other sessions that are located in the same module, which include academic policies and procedure, attendance policy, and UGME policies & procedures. Even for the specific sessions that are dedicated to professionalism in the module, professionalism is often accompanied by policies and procedures in the session titles. The other sessions on professionalism include: professionalism & social media, party like a pro, and SMSS professionalism talk. The focus of these sessions and the impact they have on medical students’ learning experiences will be addressed in the next two sections, which focus on the informal curriculum and hidden curriculum.

5.2.1.2 Informal curriculum

As mentioned earlier, the CoM’s statements on professionalism, which cover many important dimensions of medical professionalism, are only briefly mentioned during orientation. Introduction to professional identity, which is listed as a goal of the ‘Orientation and Professionalism’ module, is also barely mentioned when the formal curriculum is delivered in a classroom setting. On the contrary, the CoM’s development and implementation on the professionalism policy and emphasis on evaluating certain aspects of professionalism are fairly consistent. The difference has demonstrated that some texts that deliver expectations are fully integrated in regulating students’ behaviours while the others fulfill mostly a symbolic function and do not exert meaningful influence on students’ learning.

Participant observation of some of these sessions on professionalism and interviews with medical students and faculty have revealed three approaches of how the CoM teaches student professionalism and professionalism in professionals. The first one is teaching professionalism in policy form. The second one is reflected in the handling of incidents of professionalism concern. In the last approach, the CoM constantly reminds medical students that they are professionals and identifies the collective impact of unprofessional behaviour. Each approach will be explained in this section in more detail with quotes from interviews and notes from participant observation.

5.2.1.2.1 Teaching professionalism in policy form

The content of the sessions on professionalism, policies, & procedures, professionalism and UGME policies and procedures, and professionalism, policies and procedures in clerkship at the beginning of first, second, and third year respectively, focuses on communicating the CoM’s policies and procedures on professionalism to medical students. In these sessions, students are reminded that they are professionals now and need to exhibit behaviours that people associate with professionals. Faculty present different scenarios and explain how the professionalism policy could be applied in those scenarios. While reviewing the policies and procedures, students are also reminded of the consequences of unprofessional behaviours. One student explained the approach that the CoM takes:

I feel like it (professionalism) was almost lectured at us during our orientation week. It was...driven into us that you need to be professionals, you’re professionals now. And then almost with a heavy-handed like ‘you can get a professional breach’. So right off the bat
we were very aware of consequences if we’re not professional. So it was kind of taught to us like that and very almost like policy form. (Student Participant #2)

Course syllabi state that one of the objectives of the module “is to introduce the concept of professionalism, which is a big focus of professional identity formation”. However, there was hardly any mentioning of the concept of professional identity or PIF in the sessions observed in the module; nor was there any connection drawn between professionalism and professional identity. Unlike the CoM’s statements on professionalism, which is mentioned just briefly at the beginning of the sessions mentioned above, the CoM’s policies and procedures on professionalism, especially the SOP, continue to be explained and referred to in these sessions during the orientation week. The three flowcharts that accompany the SOP and outline the detailed procedures for resolving minor, major, and critical incidents of professionalism continue to be applied in practice.

The CoM’s professionalism policy not only specifies expectations for students and impacts students’ learning experiences, it also helps guide the faculty’s work, especially those who are responsible for the implementation of the policy and have direct encounters with medical students on professionalism issues. Many people are involved with the communication and execution of the policy, so a certain level of coordination and bureaucratic reporting (which involves both administrators and people in leadership roles) is required. Adhering to the policy and procedure also illustrates the CoM’s attempt to demonstrate fairness, transparency, consistency, and standardization in the regulation of medical students. According to one faculty:

For me, if I’m involved in that procedure, I try to follow it and use it as my guide for how I talk to the student when the issue comes up. So anything that’s in the procedure, I try to make it very clear. And I follow it so that what (others) had said at the beginning of the year is how I try to enact it. I kind of stick with the procedure, if that makes sense. (Faculty Participant #3)

In addition to teaching professionalism in the form of specific policies, the CoM also emphasizes certain aspects of professionalism when communicating the policies and procedures to medical students in lectures. Even though the CoM’s guiding principles of professionalism were mentioned briefly in the UGME policies and procedure session for SinMS I, only certain aspects of those principles were emphasized. For example, the first principle ‘respect for others’ was interpreted only with reference to students respecting physicians/preceptors. The following was observed in this session:

So, the first is respect for others. We expect you to demonstrate consideration and respect for your patients, their families, to support persons, so your colleagues and classmates, to your teachers, professionals, and the public. One of the things I was asked to mention today is that not all faculty will say, “It’s okay to call me (by first name)”. Most will say, “I expect you to call me Dr. So-and-so”. So, unless someone says to you, “It’s okay to call me by my first name”, please use Doctor as the way you speak to the faculty member. It’s just a little bit of a sign of respect. (Class Fieldnotes)
When explaining the minor incidents in the SOP, the focus was put on submitting an assignment late, being late for a class, not showing up for mandatory sessions, or using inappropriate language in email communication. The example of communication with others was provided with a particular reference to communication with administrative staff. The following instruction was noted in the session:

...to think twice about your email communication to make sure that it’s respectful. That includes, and perhaps most importantly includes, email communication with our administrative staff...the people who run your program are our very, very hardworking administrative staff. So please always, always, always treat them with respect. (Class Fieldnotes)

Faculty confirmed in the interviews that the examples given in class were generally the ones that they had to resolve with students. One faculty discussed how often the incidents of breach of professionalism happen and what types they are:

In one cohort, there might be 10 to 15 throughout an entire academic year. It’s not (a) huge (number) by any means. And they tend to be things like... you know, not submitting an assignment on time... very minor... So time management...would be another common thing that we have to deal with. (Faculty Participant #3)

As for critical incident, one faculty participant (#7) commented: “...never had anyone that would have been identified as having a critical incident”.

By teaching professionalism in policy forms (both written and verbally communicated in lectures), the CoM communicates to students the importance it places on professionalism issues and outlines the potential consequences. The written policies and the interpretation of the policies in lectures also make explicit which aspects of professionalism the CoM is spending time and efforts in monitoring and regulating. The second approach to teaching professionalism is reflected in the way incidents of breach of professionalism are handled by the College and faculty. This approach is relevant to teaching professionalism in policy form because, to some extent, the way in which the incidents should be handled is regulated by and laid out in specific details in policies and procedures.

5.2.1.2.2 Handling incidents of breach of professionalism

The CoM’S approach to teaching professionalism is also reflected in how the policies and procedures are implemented and the interactions between students and faculty when an incident occurs. The three professionalism flowcharts show that the first step for dealing with medical students’ breach of professionalism is for either the reporter, year chair, or associate dean to meet with the student. This process is continuously emphasized by faculty in explaining these policies and procedures to remind students that the intention is to deal with the concerns formatively, which is not meant to be a punitive exercise. The following explanation of the SOP was observed in session UGME policies and procedures for SinMS I:
So, it shouldn’t be if you are late by ten minutes for a lecture that you’re going to be slapped on the wrist. What should be happening is it’s a genetics class, I notice you’re late, I go up to you afterwards in a non-confrontational way and say, “Can we just chat for a bit”, and we chat.

So, it’s not us trying to be controlling of you, but you may not even recognize how things that are going on in your life are impacting your ability to function at school. (Class Fieldnotes)

In interviews, another faculty member reflected on this and observed that it was a challenge to persuade students to look at the process the same way as faculty:

Because automatically as soon as a student is informed that there was a concern about professionalism, it sort of feels like it’s a judgement against their character. And understandably so. So the first job that I do is try to clarify that and just to explain that this is meant to be informative...this doesn’t have academic repercussions. So... really the big job is to try to focus on that and to help the student see that we’re there as an ally as opposed to a punitive force that’s sort of reigning over them. (Faculty Participant #3)

The intention of faculty may be well articulated in the explanation and enforcement of the policy: “...just to have the conversation and document that we had the conversation to reinforce the idea”. However, it is difficult for students to see the faculty as an ally when students are on the receiving end of these professionalism policies, which could potentially have academic (e.g., not being promoted to the next year of training) and social consequences (e.g., being labelled as having a professionalism concern or not fit for the profession). The exact approach of students “anticipat(ing) a meeting to discuss professionalism, which may result in associated documentation” can bring real anxiety and fear to students. This will be further discussed in the section of the hidden curriculum where students’ experiences with the CoM’s approach to teaching professionalism are described.

Some faculty provided the rationale for having these policies and procedures in place and identified the importance of having clear expectations and following the procedures when needed in interviews. They believe there is some correlation between student professionalism and medical professionalism. According to one faculty:

...some literature has been interpreted to support the notion that physicians who get into difficulty with regulatory body over professional behaviours could potentially be predicted in their early career or in training so there is some consideration from the college to monitor appropriate behaviours early on or right after they get into medicine. (Faculty Participant #8)

Therefore, they emphasize the need to regulate student professionalism in training, which can be later transformed into medical professionalism in practice.

Faculty also try to draw the connections between these two types of professionalism in their meetings/conversations with students who have professionalism concerns, although not deliberately. For example, one faculty participant drew the analogy between not showing up for mandatory sessions and not showing up for clinics:
Typical issues I deal with are issues of non-attendance where a student has failed to notify anybody. And the reason why that’s important and this is one of the things that we usually have as a conversation with the student when situations like that happen is we usually sort of try to draw the analogy between... if you’re running your own clinic and you don’t show up and you don’t notify your office staff that you’re not going to be there that day, you could imagine the chaos that would ensure. So by us reinforcing the concept of if you’re not going to be in attendance, it’s important to notify the office so that we can notify other people who might be affected by you not being there. And yes, medical school is different than the clinical environment. But we’re trying to reinforce behaviours that’ll be important for clinical environment. (Faculty Participant #3)

During these conversations, faculty try to reinforce the notion that even though the nature of the task or the setting might be different, the fundamental responsibilities remain the same.

Besides delivering these expectations in policies and procedures forms, and the formal meetings with individual students who have incidents of breach of professionalism, there are other channels where students receive reminders about professionalism. One student described how an individual ‘mistake’ was turned into a collective warning for all the medical students:

...oftentimes when there’s someone that does something wrong, we kind of get a mass, generic email saying like, ‘Don’t do this’. I can tell a personal example for this... (An emergency happened) and I was trying to organize getting home to take time off. And without thinking I was just sending a bunch of emails. And I addressed someone who I should have addressed by their full name by their first name. And instead of sending me an email back saying, ‘In the future, can you please use my proper name?’ We got a mass email to the entire college saying, ‘In your interactions with all medical professionals or all professionals, please use their title until you’re invited to do otherwise’. In distancing from the issue and kind of correcting my behaviour in a roundabout and passive way, it makes me feel alienated. Because it was addressed as kind of a college-wide issue, I felt weird. (Student Participant #11)

Some students’ behaviours might not be serious enough to be dealt with formatively on an individual basis; however, they can still be turned by the CoM into learning opportunities for medical students. The latter half of the student’s comment of her mistake being addressed as “a college-wide issue” also gives a glimpse of the third approach that the CoM takes in teaching professionalism, which is identifying the collective impact of unprofessional behaviour.

5.2.1.2.3 Identifying the collective impact of unprofessional behaviour

Being a professional or being recognized as a member of a profession means the member must demonstrate the kinds of professionalism agreed upon by members within the profession. Even though medical students are still in training to be physicians, they learn early on that they are required to practice the same level of professionalism as physicians and there is a professional image that they need to uphold. As several students put it, “being a medical student means being a professional”. They can be forgiven on the knowledge aspect but not on the character and
behavioural aspects of professionalism. One of the consequences of unprofessional behaviours that is constantly told to medical students in lectures is that their individual unprofessional behaviours could potentially damage the reputation of the College or the medical profession. Students are reminded that they, as medical students at the CoM at the UofS, represent not only the College but also their future profession.

From the start of medical school, students are reminded that they are professionals, and the identity of medical student is different from that of other students on campus. The following was noted in the professionalism and social media session:

...the first thing is we keep talking about you as our junior colleagues and that really is true. The minute that you put on the white coat we are expecting more of you in terms of your professional behaviour than if you were any other undergrad on campus. (Class Fieldnotes)

Medical students are asked to treat being a medical student as a full-time job. The following was noted in the first-year overview session when attendance policy was discussed:

You’re still students, but you’re also kind of starting your career. So you want to think about med school as your job. It is work. It’s not just student life anymore so you can kind of come and go as you please. You have responsibilities. So I want you to think of this as your job. So attendance is a key component to any job. If you kind of shift your lens a little bit, you’re part of your career development now. It’s like training on the job. We’ve hired you and now you’re starting your training. (Class Fieldnotes)

It can be seen that one of the approaches that the CoM takes to remind students that they are professionals is listing certain behaviours under the professionalism umbrella (attendance is a component of professional responsibilities).

The content in sessions of professionalism and social media, party like a pro, and SMSS professionalism talk, however, illustrates another approach that the CoM utilizes, which is framing professionalism concerns as having collective impact. The idea of the relationship between personal behaviour and collective impact is drilled into students in these sessions. A common phrase observed in these sessions is: “…please think about that, that when you do something, you might be doing harm to yourself, to others, to your college”. For example, the following was observed in professionalism and social media session when the concept of public professionalism was used:

...public professionalism is something that’s also quite important. When you are out in public, whether it is for a private function or as a representative of the college you are an extension of the college. If you do something in public that would be considered unprofessional it does reflect on the college itself. So, things like public drunkenness, saying things that perhaps you wish you did not say. (Class Fieldnotes)

Another focus of professionalism and social media session is e-professionalism. The importance of not leaving any potentially unprofessional conduct on record is emphasized. For example, ten
helpful tips for the modern-day professional in the use of social media were presented in the session, including the following:

1. If you are wondering about whether to post something or not to post it, don’t!
2. Avoid polarizing opinions. You never know who you might be offending.
3. If you think you look drunk then you do, and if you don’t think you look drunk, well someone else probably does.
4. Medical school is a professional college. Therefore, post like a professional. (Class Fieldnotes)

Similarly, for the sessions party like a pro and SMSS professionalism talk, the content focuses on briefly listing the CoM’s statement on professionalism and providing scenarios of unprofessional behaviour. The following was the first scenario provided in party like a pro, titled ‘Relax lady’:

A group of medical students are attending IceBowl (Western Canada Medical School’s Hockey Tournament) and staying at a hotel. The evening involved a social event where alcohol was available. Later that night around 2am while returning to their room, some students from the group were talking loudly in the hall and laughing at the crazy things that happened at the event, while others decided to go to bed. A woman from another room asks them to quiet down. After being quiet for a moment, they start laughing again. The woman asks them to quiet down again and says she is calling the front desk. One of the students tells her, ‘Relax lady, we’re just having fun’. The woman calls the front desk and finds out that these people were medical students from U of S. (Class Fieldnotes)

The discussion on the scenario in class centered around doing a disservice to the medical program at the UofS and the medical profession. The other two scenarios provided in the party like a pro session were on not attending lectures and posting drunk pictures and videos on social media.

The CoM’s intention on identifying many behaviours under the professionalism umbrella and taking the approach of identifying collective impact of unprofessional conduct is very clear to medical students. As one student reflected on this:

They absolutely don’t want bad reputation to the College or the profession. Because unfortunately the way our society works is society makes generalizations. If one student does something, then they’re like, ‘Oh, look at that school’. People automatically connect that student to the school. So in order for school to be able to keep that image for themselves, the school is absolutely like, ‘No, please don’t do that. Respect our image and yours’. (Student Participant #9)

Faculty also emphasize the significant impact of medical students’ conduct on the social contract between medicine and society. According to one faculty member: “(understanding) how it (unprofessional behaviour) diminishes the profession as a whole when that contract is broken. Even micro infractions can cause really significant impacts”. Besides the CoM’s ‘don’t do this, don’t do that’ approach, to urge students to uphold the professional image, students are also deliberately told that a performance art is sometimes necessary. The following comment was given in the professionalism and social media session:
When you get into the clinics you’re gonna find that there will be people that will never be your best friend... I can tell you, I’ve had patients where after you’ve seen them once you go, ‘Oh, god. I hope they really don’t come back for review’. But of course they do. It’s that time...It’s nine o’clock on Monday morning, it’s time to see them again. And part of what you’ll learn to do is a little bit of performance art. You’ll go in there and you will be so happy to see them and you’ll have a smile on your face... (Class Fieldnotes)

Through the informal curriculum, the CoM selectively defines professionalism through emphasizing the aspects that are easier to define, monitor, and regulate. The formal curriculum and the three approaches that the CoM utilizes to teach student professionalism and professionalism in professionals through the informal curriculum are consistent throughout pre-clerkship and clerkship. As indicated earlier, the orientation and professionalism module is introduced in first-year orientation but also repeated to second-year and third-year medical students. Professionalism, defined and interpreted with relevance to student professionalism and professionalism in professionals, also has a consistent presence in CoM’s policies and procedures. These policies and procedures are implemented in practice to oversee and regulate students’ behaviours, in contrast to the CoM’s statement on professionalism that mostly serves symbolic functions. It has become a common practice for the CoM to emphasize to students the importance of being a professional and demonstrating professionalism. The impact of the formal curriculum and informal curriculum on medical students’ learning experiences and understanding of professionalism will be discussed in the next section of the hidden curriculum.

5.2.1.3 Hidden curriculum – lived experiences of professionalism policy for students

As indicated in the methodology chapter, the hidden aspect of the curriculum emphasized in this study is the lived experiences of medical students with the formal curriculum and informal curriculum. Utilizing data from interviews with medical students, this section describes medical students’ lived experiences with the CoM’s professionalism policy and teaching on professionalism, which is partly hidden from the faculty and the College. Students’ reflections have revealed that they are aware of the vulnerable position that they are in at the CoM. The power relations are made explicit not only through students’ lack of knowledge and skills but also when students are always scrutinized on professionalism issues to evaluate their compatibility to the medical profession.

Reflecting in part the CoM’s emphasis on student professionalism and professionalism in professionals with the teaching of professionalism, a major topic in student interviews was their experiences with and perspective on the CoM’s professionalism policy. It is important to note that when most of the interviews with medical students were conducted, the CoM was still using the breach of professionalism policy instead of the new SOP. One significant difference was that the current structure of minor, major, and critical incident was put into categories of formal breach of professionalism and informal breach of professionalism. This is why in some of the quotes in this section, the breach of professionalism was the term used by students. However, the procedures, definitions, and examples given remain similar. For example, submitting an
assignment late, which used to be in the informal breach of professionalism category is now listed as an example under minor incident. In reflecting on their learning experiences, students discussed a culture of fear and the fact that they are expected to be professionals but not given the space to be professionals.

5.2.1.3.1 A culture of fear – learning not to be unprofessional

Some students feel like the way they are learning professionalism in medical school is not learning to be professional, but learning not to be unprofessional. One student commented on the approach that medical school takes:

This (professionalism) was more of a learning aspect but I think they (students) were fearing that it was an administration wanting to scare them into not being unprofessional, rather than encouraging them to build, to grow as a professional...it’s negative rather than positive. It’s more ‘don’t do this, don’t do this, don’t do this’. (Student participant #5)

This “culture of fear”, as described by one participant, can dissuade students from wanting to learn about or engage in conversations on professionalism in medicine, which could extend to medical professionalism.

According to some students, the word ‘professionalism’ is used sometimes too casually in medical school, diminishing the meaning of the concept for students. This leads to cynicism among students because of the emphasis on a very narrow definition of the term and neglect of other important dimensions. One student reflected on this:

The title of your project definitely caught my eye. I once said to one of the faculty, ‘I don’t even know what professionalism is any more’. Because that word is just thrown around in medical school like it’s nothing... Some of the behaviour I see is not professionalism and it never gets dealt with. But then these breaches of professionalism are thrown around like candy... The same goes with the definition of unprofessionalism and the boundary between professionalism and breach of professionalism. So is not coming to a lecture not professional all of a sudden when we haven’t had to do it for two years? Is writing an email with a concern about something unprofessional because you brought to light a problem? (Student participant #6)

The example illustrates that there is some disagreement about what constitutes professionalism and unprofessionalism among the CoM and students, especially on the minor incidents of unprofessional behaviour, which were previously covered under the informal breaches of professionalism.

The informal breach of professionalism is also the category that students tend to have most complaints about within the professionalism policy and think it is “happening far too frequently for minor reasons”. One student shared the perspective on submitting an assignment late as a breach of professionalism and its consequence:
So for example, if somebody is late in submitting their assignment...they will give you an informal breach of professionalism, which to me, is a little too excessive... We’re there eight months of the year. It’s impossible to go through school without having any problems, right? And we have up until 11:59 p.m. to submit them for every assignment. And if somebody submits it at 12:00 which is one minute later, they will get a professional breach... There are people who have gotten it over what I call a stupid reason, because being one minute late was ridiculous...what they do is they have a couple of faculty members sit down with you. They try to understand your problem... But...the term used for it is not fair. It’s not a professional breach at all. But they just give it that term. (Student Participant #9)

From this example we can see that the CoM establishes policies and procedures on professionalism which are strictly followed and applied through tools (for example, the learning management system – Blackboard – that automatically flags late assignments) and by staff to regulate students’ behaviours. The breach of professionalism policy, which was later changed to the SOP, has direct impact on students’ learning experiences, as indicated by one student:

...and then just trying to resolve it was too complicated because...they need so many different people to talk about it that it was difficult to resolve, I think, for the student. And so that was quite stressful for them... I think they’re a little too willing to try and regulate students’ behaviour very strictly. (Student Participant #3)

Students also feel that sometimes the practice of the breach of professionalism policy is not grounded in legitimate reasons. This concern is specific to clerkship (this is included here as it is still on the discussion of student professionalism and professionalism in professionals). In contrast to some of the concrete examples of breaches of professionalism in pre-clerkship where classes take up most of students’ time, the definition of professionalism and the application of the policy in clerkship can be more ambiguous. As clerkship is less structured with learning happening more often on interpersonal levels and in much smaller groups, and rules not so black and white, students indicated that sometimes the report of professionalism issues were based on preceptors’ personal preferences. For example, one student reflected on this:

Informal breaches of professionalism are used I think in instances in which they’re not appropriate to control student behaviour based on the personal preferences of the preceptors, rather than actual professional concerns. You know, professionalism is something that should be about the patients and their experience with the health care system, and not the preceptors and their experiences with the medical students which is how it gets used sometimes...things like taking holidays at times that are inconvenient for preceptors; people have been written up for that. People have been written up for being late because they’ve been held up providing patient care when they needed to say, for example, go round with the preceptor. (Student Participant #10)

It is important to note that not all the faculty interviewed at the CoM approach the concept of professionalism in medicine the same way as identified earlier in the formal and informal curriculum. Faculty who are not invested in the establishment and implementation of the CoM’s
professionalism policy might not be familiar with the policy. Furthermore, some faculty hold quite different views on the CoM’s professionalism policy and consider it a counterproductive approach to leadership. According to one faculty:

I thought that (college’s professionalism policy) was actually a little bit damaging. It destroyed...it could have destroyed some of the trust and good will between the medical students and the administration by using these far too often... I wouldn’t treat adults that way... I thought it didn’t emphasize the importance of the community getting the assignments in. I didn’t think it was based in reality. It was an administrative convenience. So to me I think it really sends the wrong message... Unfortunately then I think what I’m seeing is through these policies supporting approaches to leadership that are actually counterproductive. (Faculty Participant #1)

The following comment from a student confirmed this counterproductive and damaging impact of the tension between students and administration trying to regulate them:

First year (administrators) were more tolerant and that’s why we had a better relationship with them. Because as a whole class you have to be...again it comes down to if they’re nice to us, we are nice to them. If they are creating problems for us or they’re not helping us out, we are going to create more problems. That happens inherently. (Student Participant #9)

The formal curriculum and informal curriculum on professionalism has created a culture of fear within the CoM, which leads to stress and anxiety on students. As an administrative convenience to regulate students’ behaviour, the professionalism policy has made students terrified of their behaviours being seen or misconstrued as unprofessional. It has also, ironically, given students the impression that they do not need to develop professionalism; they just need to not be labelled as unprofessional. The cynicism about professionalism among students is further exacerbated when they are told they are colleagues but feel they are being treated differently (more harshly) than faculty with professionalism issues.

5.2.1.3.2 Expected to be professionals but treated as children – not given the space to be professionals

Relevant to the culture of fear in teaching professionalism, students also feel in medical school they are expected to be professionals but are treated as children. Medical students are asked to demonstrate professionalism in everything that they do. With the policies on professionalism being strictly enforced, students are asking for more leniency in several respects.

Students are asking for some leniency in how expectations and regulations are enforced. Medical training is a learning process and mistakes and setbacks are bound to happen. Students think it is their self-reflection on those moments of mistakes and setbacks that makes a difference on their learning to be professionals:

And certainly as students...I’m kind of surprised that I’ve already recognized some things I’ve done, or experiences I’ve had, where I was kind of hard on myself, ‘Oh I shouldn’t
have done that, that shouldn’t have happened’. But you know, I look back and say, ‘Well, I’m in medical school, I’m learning to be a professional. That’s kind of what it’s all about. I recognize the mistakes I’ve made and can improve upon them. So I think the big discord or gap would be that aspect of leniency... That’s what this process is all about. (Student Participant #16)

Medical school has a structure in place that delivers rules and expected behaviour; however, it often fails to recognize the agency of students in a positive way. Students are not just passive receivers of expectations, which they must actively engage with to produce a practice that is reflective of the situation that comes with competing priorities. As medical students get more familiar with their learning environment, their engagement with rules and expectations is also part of the process of understanding themselves and developing the confidence or a sense of ontological security (Giddens, 1984) in the emerging medical student identity.

Students feel like they are expected to act in accordance with the same level of professionalism but are treated more harshly and with much more regulation compared to others, either residents or faculty, or even support staff at the CoM. One student discussed the disconnect between being expected to be professionals and not being treated as professionals:

Because where it doesn’t connect is that when you are a professional, you’re expected to act like an adult and a professional. And that means that you have control over whether or not you show up... Someone’s not waiting for you when you get to work and saying, ‘Oh, you’re five minutes late. You’re unprofessional.’ I feel like even when you are a resident, you’re just in control of – I don’t know how to explain it. You’re not being watched for little things...you aren’t going to get these little emails saying that’s a breach of professionalism. I always felt like I was being treated like a student but expected to be an adult. Or treated like a child but expected to be an adult, but then not given the space to be an adult. (Student Participant #6)

Students also reflected on the disconnect between what they are asked to do and what they observe physicians do. One student discussed the expectation of being on time:

Largely I would say, maybe just because students in medical school were recently students in other colleges or have been students – recently tied to being in classrooms. Whereas staff and preceptors and physicians are a little more separated, that almost universally students are on time. There’s a few that aren’t, but students are very good at being on time and respecting deadlines. Whereas I would say staff, whether it’s faculty or physician when we’re in the hospitals, their respect of timelines is much less strict. I would say almost a day did not go by throughout school that a staff or a physician wasn’t late for something. (Student Participant #15)

The specific observed gap of medical students and faculty being treated differently leads to students’ attitude of ‘dealing with it’ while they are in training. It also contributes to cynicism among students, which makes them less interested in or more fearful of reporting unprofessional behaviours of others or taking initiatives to change the culture of either their learning institution or the profession. According to one student:
I don’t spend too much focusing on what the standards are for professionalism because… I think they fall short in some places because you hear about a lot of preceptors that maybe get away with some very questionable activity just because they’re faculty and they’ve been there forever. But then on the other hand, you have medical students that get written up on professional concerns for things that are totally ridiculous. So I think if I would say anything about professionalism and standards in the medical community is I feel that rank and experience get a little bit too much – people get too much leeway based on their rank and experience. Or they get punished too severely based on their lack of experience. (Student Participant #10)

The above described students’ learning experiences, to some extent, are the direct result of the different status that faculty and students hold in the medical community and the power relations between them. These will be further explored in the next two chapters.

The culture of fear and not given the space or leeway to navigate the pathway to professionals in medical training, contributed by being monitored strictly, could bring stress to medical students and lead to tension between them, and preceptors and administrators. They also lay the foundation for students’ attitudes towards professionalism issues. As mentioned earlier, this project was conducted during a period when there were some changes made to the breach of professionalism policy. The CoM’s professionalism policy was changed from the breach of professionalism policy to the SOP. Some faculty reflected on the CoM’s intention and efforts in addressing students’ concerns about the breach of professionalism policy, some of which were reflected in students’ course evaluation or curriculum feedback. The intention was to incorporate students’ feedback and allow them to take potential unprofessional incidents into learning opportunities. One faculty member reflected on the changes:

I still think students are having a difficult time reconciling that. But certainly our new procedures have reduced the stigma toward what is a professionalism issue. So I think it’s helped students to feel easier about it, less tension, less like we’re holding it over them all the time. so I do think that they have a better – a healthier perception about what the policy or what the procedure is. But on a one-on-one basis, I still think that many students…still feel kind of upset about it. (Faculty Participant #3)

This worry is confirmed by the students’ interviews. Even though the language has changed, should an incident happen (however minor it is), a conversation will still be initiated and the incident will still be documented. So far, the changes, as one student identified as “rewording”, have made little impact on students’ perception of and experiences with the CoM’s professionalism policy.

5.2.1.4 Summary of 5.2.1

Student professionalism and professionalism in professionals are not clearly defined in either the formal curriculum or the informal curriculum at the CoM but cover many dimensions of the professional and personal life of medical students. The two types of professionalism are very important and intertwined components of the professionalism discussion at the CoM. The “life
skills” – termed by one medical student – are regulated by medical school in very concrete ways at both policy and practice levels. Through establishing, presenting, and interpreting its statement on professionalism and other policies and procedures on professionalism, the CoM introduces students to the concept of professionalism, and most importantly, the CoM’s definition of professionalism and its focus on professionalism. Medical students learn that in medical school, submitting an assignment late warrants not only deduction in marks (a universal practice in course policy), but also a talk with the administration to understand the situation.

The CoM’s statement on professionalism, which addresses the bigger picture of medical professionalism and how it serves the foundation of the contract between medicine and society, serves mostly a symbolic function and is completely overshadowed by the discussion on student professionalism and professionalism in professionals. The CoM gives a very narrow definition of the concept of professionalism to medical students by defining and explaining it with specific emphasis on student professionalism and professionalism in professional policy. The institutional practice fails to acknowledge the impact of learning environment or the complicated and dynamic nature of professionalism. The emphasis is on avoiding unprofessionalism rather than on developing professionalism. The CoM’s focus on student professionalism and professionalism in professionals is further enhanced through the informal curriculum, in which protecting the image and reputation of the CoM and the medical profession is made evident as the priority.

The CoM’s stated intention to treat medical students as colleagues conflicts with its practice of strictly monitoring and regulating their behaviour, creating a gap or disconnect for medical students. Creating a culture of fear can have a counterproductive impact on students’ interest in engaging themselves with the concept of professionalism in medicine, promoting cynicism especially when such preaching and regulations apply to only medical students but not faculty. The next section discusses the learning opportunities of and students’ experiences with medical professionalism – the professionalism component that is unique to the practice of medicine and essential to being a ‘good doctor’ – in pre-clerkship.

5.2.2 Medical professionalism and physician roles

In this section, I describe the learning opportunities related to medical professionalism and students’ experiences with them in pre-clerkship. These learning opportunities include classroom teaching of medical professionalism and experiential learning opportunities that are intended to allow medical students to explore the non-medical expert CanMEDS roles. The skills and competencies to achieve these learning objectives are the components of medical professionalism defined in this study even though the concept of professionalism is rarely explicitly discussed in these learning opportunities. This section, like the previous one, is organized by focusing, respectively, on the formal curriculum, informal curriculum, and hidden curriculum. However, there was less opportunity to conduct participant observation due to schedule conflicts and some faculty’s hesitation or non-reply to my requests to observe. I focus on describing students’ learning experiences to analyze the efficiency and effectiveness of the teaching of medical professionalism in pre-clerkship.
The M&S courses and their experiential learning modules cover many important dimensions of medical professionalism that could support students to perform the physician roles. However, there are many instructors who are responsible for teaching the courses and most only cover one or two topics. Because connections are rarely drawn among the different topics, they are not integrated to effectively support transformative learning for students. Despite the fact that patient- and family-centred care, interprofessional practice, and community-based health care are presented in lectures, students spend limited time in the communities and cannot sufficiently develop their skills in these areas. Students can appreciate the importance of these qualities; however, their understanding of knowledge and skills is mostly theoretical. Institutional practices on teaching, which deliver tacit knowledge that contrasts with the formal curriculum, contribute to students’ devaluation of the M&S courses and the non-medical expert physician roles.

5.2.2.1 Formal curriculum

The formal curriculum on medical professionalism and physician roles includes lectures that happen in big groups and experiential learning that happen in small groups or is scheduled for individual learning. These activities illuminate the social and political contexts of health care, patient-and family-centered care, interprofessional practice, and health needs in the communities, especially underserved communities. In describing these learning opportunities, I focus on identifying the format of learning, learning objectives of various sessions, and the time commitment required of students.

5.2.2.1.1 Classroom teaching of medical professionalism and physician roles – M&S

M&S I, II, III, and IV are four courses in the M&S series. Each of these four courses has a different focus: introduction to patients, health, and medicine for M&S I; public health and preventive (community) medicine for M&S II; meeting patient needs through the health care system for M&S III; physician roles and leadership for M&S IV. All four courses include both large-group lectures and experiential learning modules. This section describes the large-group lectures in M&S courses.

In M&S I, “…students explore concepts of the biopsychosocial model, health and illness, patient- and family-centred care (PFCC), indigenous health and healing, culture, life course, resilience, systems thinking and change, physician roles and basics of health research.” The topics of M&S II “include the causes of good health or illness in communities; prevention; screening; social determinants of health; health equity; health promotion; communicable disease control; environmental health; epidemiology and biostatistics fundamentals; research and critical appraisal; and public health ethics.” For M&S III, topics covered “include the structure and function of Canada’s Health Care System, health care reform, Medicine and Law Interprofessional Experience, quality improvement and patient safety, and physician organizations.” The M&S III “explores the health care system context for meeting patient and societal health care needs.” The last course of the series, M&S IV introduces students to “physician leadership, debate, knowledge translation, global health and occupational health.” It is stated in the M&S IV syllabus
that “this course explores the context for the practice of medicine involving many of the non-medical expert CanMEDS roles.” It is important to note that most topics in the M&S courses account for one standard session, which is 50 minutes, while a few topics account for two sessions or one session that is longer than 50 minutes. What is also worth noticing is the fact that many instructors can be involved with the M&S series (each course also has a course chair and a course director or two co-directors), especially M&S I and M&S III. Instructors who serve as course chair or course director may be responsible for teaching more sessions; however, some instructors are brought in to teach one specific session that they have expertise in.

5.2.2.1.2 Experiential learning opportunities in pre-clerkship

Medical students are introduced to some experiential learning opportunities in pre-clerkship. These opportunities are located within the M&S series, SinMS series, and Clinical Skills series. This section introduces the formal curriculum on these learning opportunities. The experiential learning opportunities in M&S series focus on allowing students to see how physicians can contribute to their communities and through the health care system, and appreciate the relationships between physicians and patients and the humanities and arts aspects of medicine. The SinMS series provide shadowing experiences to medical students. Even though the name of the Clinical Skills series indicates the focus, this series also emphasizes communication, which is identified by students as an important learning opportunity related to medical professionalism. This series is put under this section as the format of the series is primarily small-group learning.

5.2.2.1.2.1 Experiential learning modules in M&S

The M&S series includes four experiential learning modules: Patient- & Family- centered Care Learning Experiences (PFCC Module), Experiences in the Community (EC Module), Community & Workplace Centered Learning Experiences (CWCLE) module, and the module of Arts & Humanities. It is important to note that for all the four modules, there is an in-class lecture/discussion component.

For M&S I (first year, term 1) and II (first year, term 2), medical students need to complete the PFCC Module and EC Module. The PFCC module “provides students with authentic experiences of health and health care from the perspective of patients. The student will seek to understand the patient/client/family experience and implications for future practice” (M&S I syllabus). The module objectives are listed in the syllabi as the following:

1. Identify PFCC system drivers that influence the health care experience.
2. Suggest system changes required to advance from system-centered care to achieve PFCC.
3. Identify examples and non-examples of the pillars of PFCC.
4. Describe knowledge, attitudes, and skills related to PFCC required for future practice.

Term 1 includes an introductory seminar, in which students are introduced to key concepts related to PFCC. Medical students need to attend two patient advisor meetings (small-group meetings) and one patient narratives session (a large-group presentation and discussion) in both
terms to successfully complete the modules. Students also have the opportunity to arrange a supplementary shadowing experience with their patient advisor, which is optional. The PFCC module accounts for 10 hours of the first-year curriculum.

In common with the PFCC module, the EC module also runs in both M&S I and II. For this module, students are required to complete one of the three following options: Community Experience (CE); Interprofessional Community Services Learning Program (CSLP); and Making the Links/Certificate in Global Health (MTL). There are two module level objectives listed in M&S course syllabi: “1. Describe how various physician (CanMEDS) roles can contribute to the overall well-being and health of patients, families, communities, and populations. 2. Discuss factors that impact patients and communities encountered during your experience.” CE is “a one-week clinical observership experience in a rural/remote or urban underserved community,” which can be self-directed or college coordinated. The timing/duration of this option is 40 hours after the end of Term 2. CSLP is “a longitudinal interprofessional volunteering experiences with a student partner from Pharmacy, doing non-clinical work with a community-based organization serving people in underserved communities in Saskatoon.” The timing/duration of CSLP is 45 hours over Term 1 and 2. MTL “combines academic courses and experiential learning in marginalized, underserved communities locally and globally and runs over Years 1 & 2 with a community-based experience each summer.”

The CWCLE module is the equivalent of the PFCC module and EC module in the second year of medical school and is a component of M&S III (second year, term 1) and IV (second-year, term 2). Students are expected to “integrate and extend attitudes, skills, and knowledge about the social determinants of health (SDOH) (education, income, food security, housing, health services, etc.) and learn how to better practice medicine by accessing community resources for patients’ benefit” (M&S III syllabus). The module objectives are listed in the course syllabi as the following:

1. Explain how the community agency or workplace selected addresses the SDOH of its clients, employees and/or volunteers.
2. Identify how socio-political context affects the work of community agencies in addressing SDOH.
3. Explain the role of work, working conditions, and occupational health and safety policies on health and well-being of employees/volunteers at the agency or workplace selected.
4. Explain the roles physicians can play in working with community agencies and workplaces to enhance health and well-being.
5. Promote relationships with community agencies or workplaces selected to collaborate with and advocate for initiatives addressing SDOH.

The CWCLE module includes the module orientation, community plunge (a three-hour community-immersed event), 9 hours with a placement in a community agency or workplace, and a one-hour in-class mixer at which students sharing their community learning experiences. This module accounts for 14 hours of the second-year curriculum.
The module of Arts & Humanities is provided in *M&S II, III, and IV*. Several streams are offered for the module in different terms with slight variations. The streams include: figure drawing, photography, history of medicine, literature in medicine, writing your medical experience, philosophy, drama, and singing. The objectives of the module for each term also vary but are similar. The module objectives for *M&S II* are provided here as an example:

1. Represent qualities of the arts/humanities that reveal complexities of the human condition, making them an important component of medical education (e.g. uncertainty/doubt/ambiguity, human complexity/variability, resilience, creativity, patient perspective, empathy, critical thinking).
2. Link their arts/humanities experience to clinical experiences both cognitively and emotionally through reflection.

### 5.2.2.1.2.2 Shadowing in *SinMS*

For pre-clerkship students, shadowing offers the best chance to observe clinical practice. Shadowing is one of the modules for *SinMS I* and *II*. The module objective is to explore “career options and physician roles through observations in a variety of health care settings” (*SinMS I and II* syllabi). Students are asked to complete “at least ten hours of shadowing for the academic year” in Year I and Year 2. According to the *SinMS I* syllabus:

Students are encouraged to shadow (observe) physicians from a variety of disciplines and are also encouraged to shadow non-physician health care providers… Students are encouraged to reflect on their shadowing experiences and how they relate to the knowledge, skills, and attitudes reflected in the program learning objectives.

For the 10 hours of shadowing required of *SinMS II*, “Students will shadow a MD practitioner for a minimum of 5 hours...a non MD practitioner for a minimum of 3 hours...a clerk for a minimum of 2 hours.” Students may optionally shadow over the summer between Years 1 and 2, and Years 2 and 3.

### 5.2.2.1.2.3 Communication in *Clinical Skills*

*Clinical Skills*, a course which consists of *Clinical Skills I, II, III, IV*:

is designed to assist the students in developing fundamental clinical skills upon which they will build throughout their professional lives. Interviewing, communication skills, basic physical examination skills, and foundations of clinical reasoning are the focus of the course. The development of effective and caring relationships with patients is fundamental to the success of this course and all future clinical experiences. (*Clinical skills I* syllabus)

The course is offered through three methods that include: facilitated small-group learning sessions with simulated patients; large group sessions; and independent self-directed learning. Among the three methods, the majority of the course time is dedicated to small-group learning. According to one faculty, these small-group sessions are facilitated “in a simulated environment and everything has been standardized – the simulated patient has a standardized scenario so everything is somehow controlled.” Two of the course objectives that are consistent through the Clinical Skills series are: “Establish ethical relationships with patients characterized by understanding, trust and empathy; Exhibit professional behaviour consistently including: integrity; responsibility; respect for and effective working relationship with patients, faculty, staff and peers; appropriate attire.”

In August 2014, the CoM introduced the new undergraduate medical curriculum – the 2+2 curriculum. Since the introduction of the new curriculum, the teaching of social and humanistic aspects of medicine has been more structured and organized, and more experiential learning opportunities in the communities have been added to the 4-year MD curriculum. However, some of the content on basic science in the previous first two years was condensed into the new first-year because the previous 5-year program was reduced to the 4-year program. This makes the first year of medical school, and pre-clerkship in general, a very busy schedule. The formal curriculum on medical professionalism and physician roles is a combination of classroom teaching and experiential learning opportunities and covers a wide range of areas and topics. However, the M&S series and experiential learning modules account for a very limited portion of the overall MD curriculum. Because of this, the time spent on each area or topic, or the time students spend in the community, is very limited.

The next section presents some data from participant observation of classroom teaching of medical professionalism and physician roles, which is limited due to reasons identified earlier. The focus is determining which aspects of medical professionalism are being emphasized in classroom teaching and experiential learning opportunities, and the mechanisms of teaching medical professionalism. The participant observation data is complemented by the interviews with both medical students and faculty involved in the teaching of medical professionalism and physician roles, which will be discussed in the hidden curriculum. By comparing the formal curriculum and informal curriculum to the hidden curriculum, we can have a better idea of students’ learning experiences and analyze the extent to which these mechanisms can enable students to achieve the learning outcomes identified in the syllabus.

5.2.2.2 Informal curriculum

This section presents data obtained through participant observation of some sessions of classroom teaching of M&S courses, including Introduction to medical arts and humanities, Introduction to Community Experience Module, and Professionalism and physician roles, which were sessions in M&S courses in the Fall term of 2017. I seek to reveal the overarching themes of the teaching and learning of medical professionalism and physician roles in pre-clerkship through understanding how these learning opportunities are introduced to students and what learning objectives are emphasized in these sessions.
5.2.2.2.1 Definition of professionalism

*Professionalism and physician roles* was one of the rare occasions in which professionalism was considered through the lens of medical professionalism. This session was available when the participation observation was conducted for the 2017-2018 academic year; however, it was no longer one of the sessions in M&S courses for the 2019-2020 academic year. The two topics in the session title are distinct but have a natural fit, as explained by the instructor: “The first part is what is professionalism, and obviously it’s going to get a little bit into what that actually means for the role of the physician. The next presentation is specifically about CanMEDS (roles) and how they fit together.”

The first question posted to students in the professionalism session was: What is professionalism to you? Below is the instructor’s summary of students’ answers:

You’re responsible and accountable to society and others...patients;  
There’s a sense that you need to do your job really well, that you’re striving for excellence;  
Not only do you just participate but you actually...there’s a sense of leadership in professionalism;  
There’s an element of respect for all those around you and you work with, but also the system as a whole because ultimately it’s made up of all these parts;  
High standards in the way we communicate, the way we act and behave, how we look;  
Working within our scope of practice;  
Working...again, this is striving for excellence as well but having patient-centered care and interprofessional standards;  
Being a representative of your profession and representing it in a certain way;  
Boundaries in work and life, with elements of self-care and care for others;  
Integrity and humility. (Class Fieldnotes)

In contrast to the orientation week’s focus on student professionalism and regulation of student behaviour, here students discussed elements of the medical professionalism.

With the definition of professionalism, the instructor also emphasized that professionalism is a social construct that varies according to context and individual perspectives. Below are two of the observed examples:

We talked about how (CanMEDS) is a cultural document, a cultural notion. But it’s also defined by a largely certain group of people in society, people who’re practicing in this realm. It makes me wonder what the larger society would think of these documents. For example, there’re places in Saskatchewan or places all over the world where people don’t have very good access to any kind of health care providers, let alone a physician. Do you think somebody living in a rural small town that has lost its hospital or a lot of physicians would think that it would be a part of professionalism to see physicians work collaboratively with other health care providers to make sure that everyone has the best access possible? Maybe that would be seen as a part of professionalism.  
And what about other health care providers? Physicians...play a certain role and we have to be perhaps a little bit more humble. Often our discussions are not inclusive of our allied
health care providers, let alone healers from other traditions and these are the people that we’re incredibly reliant on. (Class Fieldnotes)

The instructor asked the students to think about professionalism from the perspective of the needs of patients and within the social context in which health care is provided.

Students also addressed the ambiguity of the definition of professionalism and the conflict between what is stated in professionalism documents and what they observe in practice. During the discussion, one student commented that some of the concepts listed in professionalism documents are not clearly defined. The instructor acknowledged and commented on the concern:

They’re always drawing on terms that are a bit more abstract. Integrity, for example, is a nice word, it kind of gives you this nice feeling, someone with integrity or this person has so much integrity. But what does it actually mean? (Class Fieldnotes)

Without clear definitions or concrete policies, the qualities and characteristics listed in the documents can lose meanings in the context of medicine and medical practice, and serve mostly symbolic functions by simply existing in the documents. One item that students were quite interested in was the discussion around physicians’ wellness and self-care. One student commented on the conflict between what is stated in paper about physicians’ wellbeing, and what they see physicians do and are expected to do in practice. Below is the instructor’s response:

A lot of these are aspirational (students laugh). So it says there and we can hold people we work with to these standards. After all, these are being produced by professionals within this group. So when we see the inconsistencies, to me, that’s a problem. I would say, keep your eyes open cause you’re actually going to see this conflict quite a bit... How can you be all of these adjective and possess all these values and behave constantly in all these ways if you’re not well yourself. (Class Fieldnotes)

The values and aspirations are made clear through the formal curriculum and some of the informal curriculum. However, they need to be demonstrated through behaviours and be consistent throughout the different types of curricula, including the informal curriculum and the hidden curriculum that are very powerful for influencing students’ perceptions and behaviours. The subtle and taken-for-granted nature of this aspect of learning was also deliberately addressed by the instructor:

What we’re talking about is about social norms and behaviours, basically, ideas that we’re exposed to...even though no one likely sat down and said, ‘this is professionalism in medical school’. We pull these things from the subtext, between words, there’s a lot of polite ways to say it, but it’s basically part of our socialization. (Class Fieldnotes)

The inclusion of physician wellbeing and self-care reflects the constant evolving nature of the definition of professionalism. In discussing this, the instructor commented: “The things we talk about probably have a lot to do with our current social environment. We’re always creating and recreating. It comes from somewhere but it moves and evolves and there’re new influences.”

The concept of social accountability, as a new institutional priority, was also introduced with reference to professionalism and the instructor addressed the responsibility of physicians not
just at the level of physician-patient interactions but also providing adequate care at a societal level. According to the instructor:

There’s actually, to me, a very clear evolution…in the way we talk about these things, the way we bring competencies into discussion. But also how we direct care, not just care in general but to actually a more socially accountable approach to care – we’re actually directing it to people who’re in greater needs and that comes up more prominently in these documents but is basically absent in others. (Class Fieldnotes)

The concept of professionalism was defined fairly broadly in this one particular session on professionalism, partially due to the instructor’s training and practice background. It was defined as an evolving concept that centers around the health needs and expectations of patients and populations. The definitional issue with professionalism was also honestly discussed, so was the gap between the expectations listed as aspirations in professionalism documents and the realities in practice. The next session on physician roles (CanMEDS roles) provided some concrete principles through which physicians can practice professionalism.

5.2.2.2 Competency framework – CanMEDS roles

The main objective of the M&S courses is for students to develop the knowledge and skills to succeed in performing the non-traditional roles of physicians, which are categorized into core competencies in the CanMEDS framework. Developed by the Royal College of Physicians and Surgeons of Canada and formally adopted by the Royal College in 1996, the CanMEDS framework has been updated twice in 2005 and 2015, and “has become the most widely accepted and applied physician competency framework in the world” (Royal College, 2020). The framework “define(s) the necessary competencies for all areas of medical practice and provide(s) a comprehensive foundation for medical education and practice in Canada” (Royal College, 2020) and includes the seven physician roles of medical expert, professional, communicator, collaborator, leader, scholar, and health advocate.

The transition in medical education from sole focus on the medical expert role to a much more comprehensive framework of competencies that, according to one instructor, “all physicians in training and in practice actually need to have” is emphasized throughout the M&S courses. The following note was taken from the session on physician roles:

It’s well recognized now that we should be more deliberate with the way we’re trained in medical school… So this competency framework is going to be more and more integrated into undergraduate medical education in the way that people are teaching, in the way that people assess your performance, and probably how they decide if you’re gonna advance or not. So these are quite important for the way that you work...medical expert is perhaps in the middle or the overarching but it’s much more than that and there’s emphasis on all sorts of things...maybe 20 years ago we didn’t think physicians were required to know or take part. (Class Fieldnotes)
All these roles that physicians are required to play collectively define the responsibilities of the profession of medicine with the ultimate goal of improving patient care. The following message was from one of the videos played in the session on *physician roles*:

> Although they’re defined as separate roles, they clearly overlap and one could consider them all components of professionalism, which we’re all supposed to be as physicians. We have significant responsibility not only to our practice but to greater society and this is a nice way of thinking about the different roles that we have to play throughout our careers. (Class Fieldnotes)

The well-embedded and taken-for-granted perception of the dominant role of medical expert was discussed during the lecture. In the following message from the session on *physician roles*, the instructor discussed the view of seeing medical expert as the only role that is important and laid out the expectations for students to understand medicine from a broad perspective:

> We know that there’s this idea that medical expert is the only thing that’s important, and even embedded into our curriculum, we still default to that in a lot of ways. We’re trying to move things around and shift and decide what is relevant and important so you can get the whole picture but you’re likely gonna see elements of that focus on the medical expert. What I would love to see is everyone comes forward with this understanding of the broadness of what it means to be a physician, looking at some of those models and incorporate that in the ways that they talk about diabetes or the way that they talk about stroke or HIV or whatever it might be. (Class Fieldnotes)

The rationale for introducing the framework and expectations earlier rather than later was also explained to students:

> Because these weren’t integrated into undergraduate medical education, people are becoming residents and saying, ‘well, what is this?’ and maybe not really embracing it. And I think that’s sort of been all of our errors that we weren’t making it a continuum into practice and that these concepts and ideas and expectations weren’t there from the beginning.

> ...to assist the learners, residents, and program directors for seeing the relevance of these roles, both in their education and hopefully they’ll be able to see the relevance in their practice ultimately when they go out and leave their training behind. I think sometimes the more junior the learners are, the more cynical they may be about these roles but as you get further and further in your training and close to practice, I think the relevance comes out so it’s very important that you’re introduced to these early. (Class Fieldnotes)

This last comment was from one of the videos played in the lecture and ironically reinforces the idea that students are only able to see the relevance or play these important roles when they go into practice. It gives the impression that students are only required to articulate the importance of these roles at the UGME level. This is further enhanced through course objectives that usually start with verbs like “explain”, “describe”, and “identify” and course assessment that is in the format of reflection paper that asks students to reflect on CanMEDS roles. These practices are in direct contrast to the message in the CanMEDS documents that these roles are the necessary
competencies that MD students should have. Besides descriptions of the overall CanMEDS framework, specific examples were also given to indicate implications for the various CanMEDS roles.

5.2.2.2.3 Examples – a glimpse into the implications for medical practice

A big component of the session physician roles focused on discussing CanMEDS roles and their implications for medical practice. The content focused on using examples, in particular work that has been done in Saskatoon or Saskatchewan, to demonstrate why the CanMEDS roles are important and what they can look at in practice. Below I include a few examples that were provided in the session to identify a few key themes of the session. The following are two of the examples provided on the role of medical expert:

Dr...has been working off on 20th Street for about 35 years... He’s someone who is constantly adapting his roles to fit what’s needed in the community. He became one of the first physicians who were doing HIV primary care because he saw the need. He was a frontrunner for addiction medicine along with others that he partnered with now. He was always stretching himself to accommodate to make sure that his patients were getting what they needed...was on call constantly because he wanted to make sure that the people he knew best, that maybe had bad experiences with the health care system would get what they needed and be treated with respect when they went into labor, for example. A hard worker and was constantly pushing his medical knowledge. So interestingly, when I talk about something like that, he’s also being an advocate...he’s being a leader. He obviously has great communication. You can’t tell a story without talking about other CanMEDs roles too.

Dr...working together with our colleagues from Open Door Society Saskatoon and Global Gathering Place, with public health and community clinic. We came together to create a first sort of emergent refugee health clinic...and then a more regular clinic which we now call the REACH clinic...so refugee engagement and community health. These physicians, even though it wasn’t part of their standard residency training, look for opportunities to learn about the health care needs of refugees, how to best communicate. They extensively use interpretation services, often over the phone, sometimes in person, so here I am talking about leaders in medical care but they’re communicators, they’re managers and leaders, they’re collaborators to get their project off the ground. (Class Fieldnotes)

Through the two examples on medical experts, the instructor tried to demonstrate that, as explicitly stated in the CanMEDS framework, the medical expert role is the integrating role and draws on the competencies included in the intrinsic roles. In both examples, several other roles, including advocate, leader, communicator, manager, and collaborator, were identified to be crucial to the role of medical expert, which further emphasize the interconnected and interdependent nature of the physician roles.
Within the 50-minute session, detailed and concrete examples were also provided about two other roles, those of communicator and collaborator. The example on communicator focused on listening and building relationships:

This is a story about someone I met—he came to see me—he’s having shortness of breath, fever, high heart rate, some chest pain and the obvious diagnosis is pneumonia and we did a chest x-ray to confirm. This was a guy who...is very passionate about his work—he works with youth. And he was okay to go home so he went on his way. One thing I tried to do is...especially with people who are sick and unstable...to touch base again to see how they’re doing. So about three days later I gave him a call and said ‘I got the x-ray result back, and like we thought it was pneumonia, how are you doing on the antibiotics?’ He said, ‘I’m feeling much better, thank you, I really appreciate the call.’ And then a couple of days later, he showed up at the clinic again and said, ‘I have these other things going on in my life and you struck me as someone who cares, which to me is really important. You’re not just here to be the doctor – diagnose and treat. In my work, I have to really care about the people I work with and you struck me as that kind of person so this is what’s going on with me.’ And now I’ve seen him two more times since then and he said to me yesterday that he’s never engaged in care like this before and all it was listening and then calling and checking in, which can be a regular thing that all of us do but clearly for some people that doesn’t always happen. (Class Fieldnotes)

The example on collaborator focused naturally on collaboration with other health care providers:

This is all about working with others...it’s more than working with others really. Collaboration is actually sharing decision-making. And I would say this one is still a little bit aspirational, that maybe this is where we’re trying to go. Because as we talked about, there’re these fixed ideas or ways of working where we value someone’s contribution more than others... Westside...is part of the community clinic but it’s distinct in that everyone is very aware that their day is so dependent on how everyone is working and feeling around them. So you show up to work and the first thing that we do is actually a group huddle so we see who’s coming in for the day and we try to create a story and an understanding about priorities for those visits. So sometimes people have been engaged in care for months or years and then they walk through the door and you want to be ready, you want to be as updated in their stories and their situations as possible. And you can’t just do that from a one practitioner model so there’s nurses, there’s outreach workers, there’s social workers, there’s sometimes addiction workers...there’s our management, nurse practitioners. It’s quite interesting and it’s a very strong model for practice. And beyond that, even throughout the day, we’re constantly sharing information and helping each other work through the day. And it makes it an incredibly enjoyable place to work and you can see that it really influences our patient care. (Class Fieldnotes)

The examples provided not only focus on individual CanMEDS roles but also centre around community needs and the needs of the patients, especially underserved populations. In these examples, the settings in which care is provided are located not in the hospitals but in the community. Furthermore, the populations that receive care are people who do not have good access to health care or may have had bad experiences with the health care system, including
people with HIV or addictions, people from the LGBTQ2 community, or refugees. Communication skill and interprofessional practice were explained and emphasized with the ultimate goal of providing what patients need and high-quality patient care.

For the limited sessions that I had observed in the M&S series, the general message is that it is important to look at the bigger picture of health care. Through listing population health data and sharing personal working experiences, the instructors asked students to think about what physicians can do in society to serve not just individual patients but also the health of the population as a whole. Below is one example from the Indigenous Health session, in which the instructor urged students to consider how health policy affects care and be prepared with knowledge and skills to better serve Indigenous people:

Think about a little bit of a broader picture. I know everybody is thinking, I really need to know how to suture... But at the end of the day, when you’re in practice, you need to know a little bit of the policies so you understand where things are coming from. But as practitioners, we have power, we have privileges, we have the ability to advocate... When we see the disparities in our community, it’s quite large and profound so everyone of you, regardless of who you end up becoming, whether you’re a family doctor, in the emergency room, surgeon, the internist...you’ll come in contact with Indigenous people, you’ll need to be able to navigate some of these systems so I encourage you to think about that. (Class Fieldnotes)

The CanMEDS roles is the fundamental framework that organizes the objectives and content of M&S series and the UGME curriculum. The informal curriculum on the classroom teaching of non-medical expert roles at the CoM has so far been focusing on introducing students to these roles without providing many opportunities for students to acquire these competencies. The informal curriculum has presented the knowledge and clear expectations; however, it has not taught students skills to successfully practice those roles (e.g. how to better advocate for patients or how to be a leader in health care). The experiential learning modules could, to some extent, supplement the classroom teaching on medical professionalism in pre-clerkship and support students to better appreciate those roles. In the next section, I present some data on the informal curriculum on experiential learning in pre-clerkship.

5.2.2.4 Experiential learning – community engagement, patient-centeredness, and interprofessional practice

Similar to many of the lecture sessions in the M&S series, the experiential learning in pre-clerkship emphasizes the concept of patient-centered care and gives students a chance to learn about the communities in which they will work in the future and build relationships with the communities. In the Introduction to EC Module, students’ options were introduced, including the expectations for each.

Below is the instructor’s introduction of the CSLP:
It involves volunteering with one of the four community-based organizations, matched with a partner from first-year pharmacy... This is not a clinical experience so the organizations that we work with for the CSLP are working typically with people who may have challenges accessing health services or may have challenges in terms of the social determinants of health, and also may have unique resources and strengths that students benefit from learning about... The placement sites [include] Global Gathering Place, SWITCH, Big Brother Big Sister, and Best Buddies. They are all experiences that students have said are very rich experiences for them... It’s a program that students have often said...is eye-opening...and really helps with their abilities to develop skills in terms of patient-centeredness and communication skills... Part of the strength of the program is developing the relationships with the people who you’re working with at the community-based organizations. It also is an interprofessional experience...you’re learning a little bit about the program and how pharmacists and physicians can work together. (Class Fieldnotes)

The other option, MTL, was introduced by one of the alumni of the program:

MTL...a very much involved experience...a very rich experience. You do two academic courses, and three experiences. There is the first-year Indigenous experience, the inner-city experience at SWITCH or SEARCH, and the advanced placement which can be in an Indigenous community or an international community... There were long-term relationships that were built. When you go and live with somebody or work in their community for six weeks, you can really establish some roots. And the learning is so experiential – it’s not the memorization or studying or preparation for an exam. It’s that type of life-long learning when you actually learn something down to its core... Those types of learning experience can be really formative and really help you in your clinical engagement for years and years to come. The genuine interactions, getting involved, showing up and being ready, and being excited to being involved with these things are really beneficial to you and to the communities that you’re involved in. (Class Fieldnotes)

The intention of CSLP and MTL is for students to learn in and from the community. Both options also have the interprofessional element (both SWITCH and SEARCH provide interprofessional care) so students can observe how health care can be provided as a team.

For the Arts and Humanities module, an introduction session was also available to students at the beginning of the academic year. The one I observed was for second-year medical students and focused on getting students’ feedback to improve the module for that year. Below the instructor explained the objective of the module before asking for feedback from the students:

The work around Arts and Humanities tend to focus more on how it enhances critical thinking, critical appraisals, problem solving, and empathy in physicians...being able to move away from strict algorism to how you can use all that medical knowledge into something that is usable by informing the patients...or you get a complex problem how you can solve it... A different way of developing some of the crucial skills for the practice of medicine. (Class Fieldnotes)
The reflections from students that were in different streams (such as music or literature) provided some insights into how the module was delivered, students’ learning experiences, and whether the module could facilitate their achievement of the learning outcomes. The streams’ relevance to the practice of medicine is a core element that determines whether students would have a positive or negative learning experience. For example, students who were in the music or photography streams found it hard to find the connection between the entire experience or the lecture component of the module and the expectations for them. Listed here is one student’s reflection on the music stream:

I don’t think any of us felt it was very relevant to medicine... It was nice we got to go on a walk and get some sounds, and have a bit reflection time but it was never mentioned really how music can help with healing in the same way of how art can help with healing. We just got a history of what music was, and then we made our songs, and then we had to kind of figure out how to associate it to our medical understanding... But a strong amount of us in the group were struggling with finding that connection. (Class Fieldnotes)

Students were forced to reflect on or connect their experiences to their medical understanding because the experience of the stream focused on music itself without drawing any connection to the practice of medicine. The literature stream, on the other hand, received mostly positive feedback. According to one student:

We had a really great opportunity to have a relationship with different texts, poems, different short stories, and things like that. One thing I remembered about our discussion was the importance of subjective experiences of illness. The main takeaway is about how it’s very easy in medicine to just get overwhelmed by looking at lab values or just look at text results or X-rays and things, to completely forget there is a person having a subjective experience of what they are going through and how relevant it is to acknowledge that experience. (Class Fieldnotes)

Students were able to gain a new perspective from participating in this module because relevance was drawn between literature and the practice of medicine (e.g., the importance of the patients’ subjective experience), which allowed them to have related discussions.

Perspective was, in fact, the theme that was emphasized in the session. In response to the student’s comment about photography above, the instructor commented:

One of the themes that has come out photography every year we’ve done it has been around perspective. And then students compare the pictures that they have taken at the same thing and how everybody had a different perspective on whatever the subject is. (Class Fieldnotes)

One student who was in the figure drawing stream also reflected on the exchange of perspectives:

I was in figure drawing and I thought it was really nice. We all drew the same thing, we looked around afterwards at everybody’s work and just...how different the same view is and the different view or aspect we took to look at the same model between work to work. (Class Fieldnotes)
In responding to this above comment, the instructor directed and related the conversation to interprofessional care and practice:

For me, those kinds of things are important. Because as a physician, we look at something from this direction, but the nurses are looking at it from here, physiotherapist might be looking at it from here...the administrators are looking at it this way... So it’s the same thing but everybody is seeing something different. So learning how to mould or melt those into a broader picture. (Class Fieldnotes)

The data on the informal curriculum on the teaching of medical professionalism provide a glimpse into the overarching themes that are delivered to students. Both the classroom teaching and experiential learning emphasize two directions that the current health care system is aiming for: patient-centered care and interprofessional practice. Through providing learning opportunities that are grounded in the communities, the informal curriculum also draws students’ attention to the needs of the community and underserved populations. The formal curriculum and informal curriculum provide a good knowledge base of medical professionalism and clear expectations, mainly through the CanMEDS framework, and some opportunities for students to appreciate the various physician roles and see them in action.

5.2.2.3 Hidden curriculum – the lived experiences of teaching and learning of medical professionalism and physician roles

This section describes the hidden curriculum in medical professionalism, discussing students’ and faculty’s lived experiences with the learning and teaching activities on medical professionalism and covering both classroom teaching and experiential learning opportunities. By analyzing these experiences and especially the hidden nature of some of these experiences, I try to evaluate the effectiveness of the formal and informal curriculum in students’ learning of professionalism in medicine.

5.2.2.3.1 Students devaluing M&S courses

The majority of students hold negative views towards the M&S courses. They are mostly seen as large-group lectures even though there are experiential learning components involved in M&S courses. This is mainly because most of these experiential modules account for a few hours of each term and do not have a consistent presence on a daily or weekly basis. Assignments are also consistently in the format of group reflective activities or reflection paper at the end of the term. Students are not very receptive to the organization of the content or the way the content is delivered. They also have concerns about the level of the content that is taught and redundancy of certain aspects of content. As one student summarized in a simple and blunt way: “M&S as a course isn’t respected.” Students also discussed the imbalance between classroom learning and experiential learning in M&S courses and advocated for more experiential learning time. Faculty’s perspective and their teaching experiences are also included in this section, which adds another layer to the discussion.
The perceived importance of M&S courses, especially compared to science courses, is a very significant factor that contributes to students’ perception of the courses and how much effort they put into these courses. According to one student:

I think as students, we perceive it as being of less importance than learning about the human body and the diseases. So yeah, it’s presented. I’m not sure it’s well-received... I think there is an identification of the relevance, but it’s just the weighting is so much more towards our basic sciences and our study of diseases. (Student Participant #1)

Students’ perceived idea of the importance of different components of the curriculum is in part due to how the lectures are delivered (large-group lectures that are not mandatory versus small-group sessions that are mandatory) and how they are evaluated (Pass/Fail versus marks). According to one student:

...the foundations course...everyone is very stressed about passing... And so sometimes the arts classes are just pushed to the wayside and a lot of those assignments are pass/fail. And so they’re almost an afterthought...students not having the motivation to really learn during those lectures and such because they’re missing the lectures to go study for foundations. Or they’re doing the assignments to just get them finished, so that they can move on to doing something that they’re afraid of failing essentially...which is unfortunate but that’s a reality. I know that there’s individuals in our class that do feel that stress of, ‘okay, I’ve got to be studying for foundations. I don’t want to quote/unquote ‘waste my time’ in content that is pass/fail anyway.’ (Student Participant #5)

Another student commented that “it was easier to study for and pass” M&S courses, which do not require students to memorize a lot of details. The MD curriculum is tightly structured with very limited time for individual learning, which results in students prioritizing their time and efforts to fulfill commitments in pre-clerkship. The M&S courses are, for many students, a lower priority due to the format of teaching and evaluation measurement, especially compared to science courses.

Students sometimes feel that the content is superficial, especially on the level that it is being taught to them. One student provided an example to illustrate how complex topics or issues covered in the course are turned into simple instructions on what to do and what not to do, which is further enhanced by the format of examination:

Like right now, the most that we get is on our final exam...one of the questions will be: a pharmaceutical rep offers you lunch, do you take it and why or why not. And they’re looking for no because that’s how they’ve taught us. It’s like their examples are very clear-cut...and I don’t think that really helps us develop or to see what other people...would react to the same situation and give different perspectives... So right now it’s very just ‘do this or don’t do that’. And it’s not challenging or developmental. (Student Participant #3)

The student further commented that providing a very simplified approach without explanation or discussion of different views in lectures can actually be counterproductive to students’ development:
Well my father is a pharmaceutical rep and so I have this idea or a pre-existing notion that pharmaceutical reps are there to help educate physicians because it would be difficult for physicians to keep up-to-date with all the medications. And even in practice, there’s been physicians who’ve said that, ‘You need pharmaceutical reps because they help sponsor events, otherwise they couldn’t get funding to put like advance or continuing education events on. Or the samples they provide help people from lower social economic status because they can’t afford full drugs’. So they talk about how beneficial it is. And then to come here and hear professors teaching those courses say, ‘Don’t deal with them at all.’ I don’t think that was a very professional approach to take. It seems counterproductive.

(Student Participant #3)

On the depth of the content that is being presented, some students also feel that they could see the relevance of the content at a superficial level, but they cannot articulate the connections to their medical training or future practice. Students argue that even for classroom teaching of medical professionalism, more dynamic and interactive debates and conversations could be utilized to further engage students in understanding the issues facing health care and coming up with potential solutions. Through this approach, students are not simply seeing things at a theoretical and abstract level; they are able to apply their knowledge and skills to real issues and see the relevance of the knowledge and skills. One student cited community health to address this concern:

I think there’s a better way to structure the way students are taught to understand how community health relates to medicine. Just when you look at the cost breakdown of how much it costs to treat things versus preventing it. And I think everyone probably recognizes that prevention is obviously where we should be focusing a little bit more on... With all the other diseases, it’s very easy for students to be like, ‘Okay, this is the problem. This is what the patient is presenting with... These are all the investigations you can use to try to figure out what’s going on. These are all the ways you could treat it’. And then it’s just stuff that students have to absorb. The same sort of thing doesn’t happen with M&S. There’s more conversation... I mean we definitely go into important ethical issues. I just think the answers to those are usually pretty straightforward. Once in a while there’ll be a question and it sparks an interesting conversation. I think M&S should be in smaller groups. I think there should be specific issues and then a debate or conversation. (Student Participant #12)

These examples illustrate that students are not satisfied with the depth of the lectures or the discussion in those lectures. Medicine and medical education emphasize the application of clinical knowledge and skills; however, they have yet to recognize the importance of the application of the knowledge and skills that support the non-medical expert physician roles. Students feel they cannot learn much in M&S sessions because they are being lectured at or tested on clear-cut principles but not how they are put into practice in real-life scenarios, which to them is a waste of time that could be dedicated to other learning opportunities. Medical school is very structured and busy and time not well spent is a significant concern for medical students.
Redundancy is another factor that contributes to the cynical attitude towards classroom teaching of professionalism. One student described students’ response hearing the same content over and over again:

We also have one professionalism lecture...and it’s the same examples...I can quote them to you...it’s been at least three times that I’ve seen that specific slide with the five examples. And I think those lectures are great because they kind of hammer home the importance of professionalism but also real stories. But telling the same stories over and over again kind of loses the message... And then people just sit back, roll their eyes...and zone out. Unfortunately. And it’s like, ‘Oh the P word! Professionalism again’. When professionalism is such an important topic. (Student Participant #11)

The CanMEDS framework is a major emphasis for classroom teaching of medical professionalism and physician roles. Medical students learn about the CanMEDS roles before medical school – when they apply to medical school and prepare for the MMI – instead of in medical school. After hearing about it so many times, it becomes “just another fact” for students without prompting reflection or engagement. The redundancy is also a concern for students with respect to assignments. According to one student:

And even in preparing for the medical school interviews, that’s one of the biggest pieces of advice. It’s like know those roles and be able to talk about them and know what they mean and stuff...We also have some assignments where we talk about the roles and give examples and how they apply. I guess it’s hard to see the value in those at the time when you’re like, ‘I have 27 other things I need to be doing! I really don’t want to write another paper about the CanMEDS roles or whatever.’ (Student Participant #4)

The above discussion is not to suggest that all medical students view the M&S courses or the topics covered in these courses as not worthy of their time and efforts. The following example of faculty’s perspective on the division between students who find these courses valuable and “fluffy” could shed a light on this:

...within (medical school), it starts very quickly I feel. We do have some students that drift towards things like MTL. They’re trying to understand more broadly what these things mean. Others I think maybe have always been a bit more predisposed to ‘this is a concrete discipline and I need to know the cold facts.’ (Faculty Participant #5)

Students’ perspective on these courses and how much they value them could also be affected by their backgrounds and the trajectories that lead them into medicine. According to one student:

I think if you sat down and asked each student one by one, I’m sure they understand the value of what comes with that kind of learning. But I think most students are so – and this depends on what kind of background students have. I think all physiology, sort of pharmacology, anatomy people, the ones that came from maybe hard science, they’re not too interested about hearing about the social aspects of medicine. (Student Participant #12)
Because of the strong sense of community in medical school and the strong connections among students, faculty are counting on some student leaders to change the hidden curriculum in medical school and promote students’ learning and a broader understanding of physician roles. As one faculty reflected:

...giving students who have an affinity towards understanding their roles more broadly than just medical experts, giving them opportunities for enriched learning in those areas, because they are often leaders within the class in terms of helping form opinion. And so our programs like MTL, the first year community service learning program, having those enriched opportunities I think is of value even though not 100% of the students get it. Because I get to do it because it changes the culture within the class to see that as being of value, service in an underserved community as being of value, and then that I think can have influence on the hidden curriculum as well. (Faculty Participant #7)

As outlined in the above discussion, there are a few reasons that the M&S courses are not valued as much as they are needed. The devaluing of the M&S courses essentially comes down to competing priorities in medical school and students comparing these courses to the science courses and prioritizing their efforts towards the science courses. The M&S courses are not respected because the knowledge and skills delivered in these courses are seen as of less value compared to the knowledge and skills in other courses. Students are experts in knowing what is expected of them to be successful in medical school and use that knowledgeability to coordinate their learning and activities. Students recognize the value of the learning objectives, while at the same time justify their lower interest in or disengagement from the courses. Such sentiment is not unique to students. In describing their teaching experiences, faculty also shared their frustration of struggling to engage students.

5.2.2.3.2 Faculty struggling to engage students

It is an understanding to the faculty that the objective of the M&S series is “touching the hearts, informing the head, and guiding the hands”. However, as explained in the formal curriculum, there are more than two dozen of instructors involved in the teaching and facilitation of the M&S series and it is common that one instructor teaches one or two sessions or facilitates one module within the courses based on their areas of expertise. In the interviews these instructors tend to focus on a certain topic with which they would like to see the students familiarize themselves with. At the same time, people who have more responsibility for organizing these courses are more likely to give an overall view of the courses and a more general description of what they would like the students to take away from these courses. One faculty described the value of the M&S series in general:

So I think it’s valuable because it does provide an important context for the practice of medicine. It helps them to understand their patients as people and their job as part of a social network that they themselves can influence and they themselves are influenced by it... So there are all those aspects of M&S that I think can add a lot to what the medical students will bring to a clinical situation. (Faculty Participant #1)
Faculty emphasize the importance of these courses even though sometimes students are not able to see the value of them at the time when they are provided. These courses not only lay the foundation but also provide students with the tools to work with the topics or issues covered in the courses in the future. Faculty recognize that theory has to be in place in order for students to practice the important dimensions of medical professionalism. One faculty used the advanced communication skills module as an example:

...how do we teach advanced communication skills when you’re breaking bad news? There’s...not necessarily steps, but a series of key things that are important to do when you’re breaking bad news to someone. Some students are naturals at it! They’re just so gifted in communicating that empathy and being good listeners and having good body language. And others really...it’s very awkward for them. But at least, if we give them...it’s appropriate at these times to say, ‘That must be very hard for you.’ They might not actually feel that empathically within them but if they can at least project those things and convey that to their patients even if it’s not sort of natural to them, then I think that we’re at least on the right track, if that makes sense. So I think it’s our responsibility to at least engage in that process. And to the extent that students take it in or not – it’s hard to control that. (Faculty Participant #3)

Another faculty made a difference between medical school’s responsibility in teaching physiology or anatomy and teaching medical professionalism:

I think something important to learn is that you cannot make – first you cannot make everyone like the topic that you like. That’s something clear. Secondly if you can impact as many students that you can, that’s an achievement and you need to accept that. There is a certain proportion of students that they perceive they are there for their careers. The topic that you’re trying to teach them is not relevant for them. So I think you shouldn’t force everyone to believe or gain certain learning, specifically in this area (M&S). It’s not like issue of learning the physiology or anatomy... But it’s opening the learning opportunity and let them take it or not. And reinforce it. And if you can’t, you did your best. (Faculty Participant #2)

These accounts, to some level, reveal some of the frustration in faculty’s teaching experiences. They also demonstrate that the broader perspective of looking at the medical profession and many important topics relevant to medical professionalism are still not seen as the essential requirements of being a competent physician. This is made clear in the comparison that these issues are “not like issue of learning the physiology or anatomy”, which are knowledge that students must master. The roles that are not medical experts are almost seen as a choice for students to make or an add-on quality for students to gain. Faculty also recognize that it is difficult to observe students over time or evaluate and provide feedback to students on skills or qualities that are expected in M&S courses due to the limited resources and time in teaching. According to one faculty member:

...but it’s hard to quantify (student performance)...cause we can just really see behaviours, we can’t evaluate the internal process. Sometimes people will exhibit the behaviour that’s
desired for the period of time that it’s required. That doesn’t mean that it’s genuine.  
(Faculty Participant #10)

Faculty who are involved in either teaching or organizing of the M&S courses could get a sense of students’ negative attitude towards classroom teaching of medical professionalism through either direct channels (course evaluation or curriculum tickets submitted by students) or indirect channels (informal discussions with students). However, they recognize that the devaluing of M&S courses is not a unique phenomenon at this medical school. According to a faculty participant (#7): “Every medical school across the country, students will tend to rate community health courses lower than their science-based, disease-centered courses. They’ll see that the disease-centered stuff is higher priority.” The pass/fail system in M&S courses was implemented as a solution to effectively evaluate medical students’ competencies while being flexible to students’ reflective experiences. Many of the assignments in the M&S courses are in the format of written reflection with students increasingly given the freedom to choose approaches of reflection that they prefer. These practices, however, potentially contribute to students’ view of M&S courses being easy to study and pass, and devaluing of the course. This continues to be a struggle for faculty in designing the courses when they try to balance achieving learning outcomes and providing flexibility, which is a common theme in students’ course evaluations and their advocacy for curriculum change.

The most common complaint about classroom teaching of medical professionalism is “the content is fluffy”. The faculty who participated in the interviews made it clear that they were listening to students and taking feedback from students to better organize and facilitate the M&S courses. According to one faculty member, there is some discussion in medical school on how to actively engage students so “they could see the relevance now instead of ten years down the road”:

Right now we are testing to promote more active learning. So they see that it’s not about the lecture...having more opportunities to reflect that it’s more a tangible matter rather than something that is a concept or idea. (Faculty Participant #2)

Another faculty member called for more experiential learning opportunities as students did:

And as many have pointed out, there’s a risk of just adding it as a list of things to understand. They are actually things to act on and that we can influence. And so making that real is one of our tasks. (Faculty Participant #5)

On the structural factors that impact the effectiveness of classroom teaching of medical professionalism, a few faculty also reflected on the structural lag, meaning that it might take some time for the CoM to see the impact of changes that have been made in the past few years. The CoM has been dealing with the issues of accreditation for the past two decades. The College was put on probation for the first time in 2002 and on a warning of probation since 2011, and eventually put on probation for the second time in 2013. The CoM was taken off probation in October 2015 and received full accreditation after a complete onsite review in 2017. During the past few years, with the accreditation challenge and CoM’s responses to restructure the college,
significant changes have been made to the UGME. New positions (new assistant deans and vice-deans of research and medical education) have also been added to improve student performance and experience as well as the CoM’s research performance.

The Division of Social Accountability, established in 2011 and later listed as one of the College’s strategic directions, is one of the recent promising changes. One faculty member reflected on the slow recognition and slow implementation from policy to practice of social accountability, one of the vertical themes of the UGME curriculum:

...with the social accountability unit, how does it fit into the structure or the curriculum? It typically ends up being a part of M&S. It ...often comes out as a single lecture so it’s often here or there. However there are efforts to make it so it’s integrated. So there is some acknowledgement that we need to weave this in. And in fact any time we talk about social accountability, we emphasize that it’s not about this is socially accountable and this isn’t but it should be our lens or our manner of doing things. How are we responsible to the communities? How do we determine what that actually means? So I think there’s a fit but the reality is the institution has its history that has brought it to today. (Faculty Participant #5)

This reflection demonstrates the difficulty of transforming medical students’ views through a single lecture without a coherent overarching theme that has a consistent presence throughout the curriculum.

Classroom teaching of medical professionalism intends to cover the social and humanistic dimensions of medicine, discuss the context of the practice of medicine, and introduce students to the different roles that physicians play in society. However, it continues to be a struggle for the CoM. Both faculty and student experiences on these learning activities reflect frustration and demonstrate insufficiency in achieving the learning objectives listed in the course syllabi. The depth of the content, the way it is delivered, and the way in which students are evaluated make the courses less relevant to what students see they will do in the future, which makes the knowledge and skills listed in M&S courses considered less important than science or clinical courses. These lectures, to a great extent, serve tokenism function to fulfill curriculum requirements and make little impact on students’ understanding of medical professionalism and their development towards the physician roles that are expected by patients and society.

For medical students to fully appreciate and apply the CanMEDS framework of physician roles, buy-in is needed at both the individual instructor and student levels, as well as the institutional level to guarantees human and financial resources to provide related learning opportunities. The vision and policies related to social accountability need to be woven into institutional practice, so they are not just serving symbolic purposes. The course content also has to be more in-depth instead of superficial or repetitive, and based in real-life situations that are often not black and white so that students can actually see the application of the content and see how people might approach the same grey situation with different perspectives.
5.2.2.3.3 Valuing experiential learning opportunities

Students identified three valuable experiential learning opportunities: the experiential learning modules included in M&S courses, Clinical Skills courses, and shadowing with health care professionals. The section focuses on students’ experiences interacting with patients and observing the work of physicians or other health care professionals.

During the interviews, students emphasized the benefits of the “experiencing” component of experiential learning in M&S courses to their understanding of medical professionalism. One student described the learning and understanding of community health and social determinants of health and discussed the benefit of the CWCLE module:

...community recognition of some social determinants of health...it was quite unbalanced that we talked about all these real-world problems and environments that exist, and we know they exist but you’ll never appreciate or come to understand what they’re like until you go in and experience them. The topic that kind of is brought about and taught is inherently about experiencing, and the classroom’s just not the environment that should be largely used to cover that... I did the (one option of CWCLE) for mine, and I really enjoyed that...you’re actually there and you get to see it, you get to talk to the people, you get to listen to the people in the real setting. I was with a nurse practitioner seeing patients in the school, and so you actually get an example – real example – of that. At the same time you’re able to discuss with community members and ask the questions that you want to ask as opposed to just being in a lecture hall. (Student Participant #16)

It is evident from the above example that students value the opportunities to experience the role of medicine and health care in the communities.

In discussing the benefit and value of experiential learning modules in M&S courses, especially in comparison to classroom teaching, students recommended reallocating time in M&S courses from lectures to experiential learning or other alternative instructional methods. They believe professionalism is “a learned trait”, which makes experiential learning a more suitable method than didactic lecture. They want medical school to revise the well-established format and structure of teaching to accommodate the learning of social and human aspects of medicine, the understanding of medical professionalism, and the different physician roles in society. It is worth mentioning that a few faculty who are responsible for facilitating the M&S courses reflected that the patient advisors from the PFCC module would want to spend more time with medical students for discussions. The community partners from the CWCLE module would also want students to spend more hours in their agencies to really appreciate how different aspects of social determinants of health could impact community and population health. These requests and suggestions, together with some students’ willingness to participate in more experiential learning, reflect a potential time investment in these modules. However, these experiential modules are currently located within the tightly scheduled M&S courses, which makes it challenging to accommodate more hours or a more integrated approach. The inflexible and highly structured nature of the curriculum restricts students’ learning experiences by directing their time and efforts to certain learning opportunities and excluding others.
Students recognize the very significant value of Clinical Skills and acknowledge that, when they have not had many clinical experiences, it is beneficial to gain some experiences and skills in a controlled setting with standardized patients. One student discussed the value of communication sessions:

We’ve had some really good sessions in Clinical Skills with advanced communication. So just the hard conversations that we need to have with patients, whether it be a hard diagnosis or bringing up the topic of setting up an advanced care directive... Those situations, they’ve been challenging at times but really good to have that experience in a controlled setting. (Student Participant #1)

The student participant further argued that the communication piece is the most valuable lesson they get on medical professionalism:

I think a lot of what I’ve learned especially from Clinical Skills and our patient interactions has been the communication piece. I think certain things like exam techniques and interpretations, those’ll come. But first and foremost you have to be able to communicate with your patients and your colleagues. And if you can’t do that, then the rest of it doesn’t really matter in my opinion. (Student Participant #1)

The following example further demonstrates that communication is an essential component of medical professionalism:

...communication sessions...were probably I think the really good demonstrations of professionalism and the sort of soft skills. A lot of those sessions was just discussion on how do you just sit with someone while they cry? How do you handle difficult situations? And there wasn’t a big professionalism banner over top of them. But I think that was a really useful way to learn, because in those more difficult situations that professionalism part is kind of make or break. Like that’s the really important times for it. (Student Participant #4)

Faculty recognize that one reason that students see the value of the communication component of professionalism in the curriculum is they could see the application of these skills or the connection to their future through practice with preceptors in small groups. According to one faculty:

I think in terms of the communication skills at the pre-clerkship level, students actually don’t see that as being fuzzy or soft. Because it’s all done in small groups and they really get practice and recognize the value of having that practice before they have those conversations for the first time with a real patient. (Faculty Participant #7)

Because students are naturally engaged in the Clinical Skills courses, faculty who are involved in both M&S and Clinical Skills courses find it much easier to teach the Clinical Skills courses and have more enjoyable teaching experiences with the Clinical Skills courses. According to one faculty member:

...the bio-psycho-social sciences. In medicine that’s not a popular topic. So it was harder in the past and it’s harder right now. But it’s harder if you don’t have the students engaged
in class... In contrast I don’t find very challenging the teaching of Clinical Skills...that’s different because they’re interested and involved...it’s different because it’s hands-on work and hands on a patient – simulated patient. That maybe promotes more fulfillment rather than being in a class and being lectured. (Faculty Participant #2)

Patient centeredness is another objective of the Clinical Skills courses and preceptors involved in facilitating these courses address this goal by including simulated patients in the interactions. The faculty member quoted above discussed his approach teaching Clinical Skills:

When we are doing a specific evaluation I always let simulated patients give some feedback to the students. Because they are the people who live the process of being interviewed or examined by the students and there are some aspects that I maybe didn’t observe or did observe but I didn’t think to highlight to the students, for instance the way that they approach the patients, how they introduce themselves, the way that they look at their eyes, the way that they show empathy to the simulated patients, and the complaints that the simulated patients bring... That is one of the most important things that they need to learn through those sessions. (Faculty Participant #2)

Students emphasize the value of patient encounters in pre-clerkship as well, even if it is with simulated patients. According to one student:

They are simulated patients. So they have a script and they just act things out, but it still gives us an opportunity to interact with people and start to build certain mannerisms. And I think it’s learning about how to conduct ourselves...and even things like appropriate draping for physical exams. I think that is the most practical way that I’ve developed my professionalism thus far. (Student Participant #1)

As mentioned in the formal curriculum section, professionalism is listed as a separate evaluation criterion in the course syllabi of Clinical Skills courses. Although there is no definition of professionalism or example of unprofessionalism besides lateness or unapproved absences in either the syllabi or evaluation forms, students understand that “we’re expected to be professional, treat them (simulated patients) as real patients, and make it very realistic”. As with the explanation of policies on professionalism in other courses, students are made aware of this evaluation strategy and the potential consequences. According to one student:

Especially in clinical skills (professionalism) really spells it out. Well every clinical skills evaluation that we have has a checkmark for professionalism. And no matter how you do in the rest of the session, if you fail the professionalism check you fail the session. I think the fact that it’s an objective on every single clinical encounter is a good reminder. (Student Participant #11)

It is, however, unclear as to how each preceptor defines professionalism in clinical encounters, and what their scope of understanding of professionalism is when evaluating students, especially whether that understanding includes good practice of communication and patient-centered skills. These courses could fall short of their potential to facilitate students’ development of
professionalism due to the pass/fail evaluation structure, the ambiguity around the concept of professionalism, and the focus on identifying unprofessional behaviour.

Clinical Skills courses cover important dimensions of medical professionalism such as communication and patient-centered care. The opportunities to practice communication and patient-centered skills with simulated patients and preceptors in small-group settings allow students to see the application of these knowledge and skills, and at the same time receive feedback from both simulated patients and preceptors. The last of the three mechanisms of experiential learning is shadowing with health care professionals, mostly physicians.

Pre-clerkship students described the value of shadowing — “just watching physicians work” — in the interviews. According to one student participant (#1): “Shadowing is really exciting, to be able to go and observe and kind of place yourself in an environment that you might see yourself practicing in the future. That’s really neat.” For pre-clerkship students who have not seen many clinical encounters, they are amazed by the application of knowledge, as explained by one student participant (#2): “…how physicians are able to take...even minimal pieces of information from the patient and put it all together.”

Students begin to observe a variety of practice styles through shadowing and imagine how they would like to practice in the future. According to one student:

I’ve had many physicians that I’ve worked with and their patients are just so overjoyed to have them as a physician. I see elements of how they have good bedside manner or that they explain things in a way that is really geared to their patients and that I’m like, ‘Alright! I took note of that’. I really want to be a physician that does something similar to that.  
(Student Participant #5)

Besides the general practice styles, there are also small but concrete behaviours that students observe through shadowing and would learn to mimic in the future. A student participant (#7) summarized this process of learning as: “…because you’re immersed in that culture of professional speech...you catch up. It just kind of becomes you.” This observation of physicians’ work happens not only in the actual learning activities of shadowing but also other times when students are around physicians. One student explained how the “picking up of little things” could gradually transform their feeling from discomfort to comfort in certain situations:

I remember...I didn’t know what to do (with my left hand) when I was listening to the chest with a stethoscope. It was just kind of hanging. Some of my classmates just put it on the bed. But I noticed where the preceptor put the left hand. And it’s a very normal place. And then when I go back to my family doctor and the family doctor is listening to my chest, I noticed that the family doctor put it on my shoulder. I don’t know if it came naturally or if that was taught...I feel like those are things that you sort of just pick up. The smoothness of being able to keep a patient comfortable...it comes with seeing other people find a way to do it. (Student Participant #12)
Students can observe and pick up both professional and unprofessional behaviours in shadowing. They try to take observed unprofessional behaviours as learning opportunities as well. As one student explained:

The unprofessional behaviours actually reinforce professionalism, I think. I analyze the situation. I like this aspect of it but I didn’t like that aspect of it. So I won’t do that but I will do this. And when the situation comes, we’ll see how it plays out. However, I’ll keep that in mind to not be like that. I would make an extra effort to not go there. (Student Participant #9)

The situation can be quite different for clerkship experiences when students have to stay on main rotations for six weeks (instead of shadowing a physician for an hour or an afternoon), and fitting into the environment, getting to know people and building their network, and getting a good evaluation are all important considerations for them. The real-life scenarios in clerkship tend to be grey instead of black and white, and there might not be clear guidelines on what is professional and what is not. This will be further discussed in the next chapter on clerkship learning opportunities.

Some faculty and students have been advocating to increase the time allocated to shadowing within the curriculum. One faculty commented that there should be more dedicated time in the curriculum for shadowing, which should also be accompanied by mentorship. According to the faculty:

I would like to see the shadowing increased... I think they should be doing 30 to 40 hours minimum of shadowing and we should make the time available for them to do that but it needs to be mentored so they go out and shadow but let’s say every month they get together in a small group or individually with a resident or a faculty member or a preceptor to talk about what they see and what they think about it and to test their observations and their impressions with people who are more experienced and also to debrief some dilemmas that they’ve witnessed, maybe ethical breaches...poor patient care, abuse...just being able to talk to people about it. I think that is really important for getting them...prepared for clerkship and for practice. (Faculty Participant #1)

This influence of mentorship is, in fact, confirmed by students. In discussing who made the biggest impact on their learning of professionalism, one student commented:

I think that the mentorship is the biggest. I have a physician that has gone above and beyond to get me (a leadership experience). I’d like to attribute a lot of that professionalism to him. And then the physicians that I’ve had the chance to shadow and be a part of their practice. And then the lecturers and our professors that carry themselves professionally and teach the content in a way that they try to make us excited about. I enjoy that excitement for things and appreciate how much work and dedication they have for their jobs. (Student Participant #5)

It is evident from this comment that students do not just shadow physicians when they are in the actual learning activity of shadowing; instead, they shadow their preceptors and their demonstration of professionalism all the time. It is through observing physicians and receiving
mentorship from physicians that students can come to realize that teaching and providing mentorship to medical students is a big part of what physicians do and hopefully perform similar roles in their future practice, especially as informal teaching is a big part of the training of competent physicians.

5.2.2.4 Summary of 5.2.2

The learning of medical professionalism at the CoM focuses on the role of physicians in society and includes both classroom teaching of medical professionalism and experiential learning in various courses. Although these learning opportunities center around the CanMEDS framework (both the content of teaching and the organization of experiential learning opportunities), there is a big gap between the CanMEDS framework and the learning objectives in these courses. The CanMEDS framework focuses on describing competencies (the definitions describe behaviours and actions that physician should take). However, at the pre-clerkship level, the objectives of the courses on medical professionalism concentrate on introducing students to the important physicians’ roles and related concepts. The expected learning outcomes are not for students to acquire these competencies but instead for students to explain why these roles are important for the practice of medicine.

This gap is reflected not only in part of the formal curriculum where these learning objectives are listed in the course syllabi, but also in the informal curriculum where students are taught the importance of these roles but do not have enough opportunities to gain the skills to perform well in these roles. The difference between the learning of the medical expert role and non-medical expert roles is quite significant. For the medical expert, the knowledge is divided into different sections, and students are taught and then tested on different subjects to make sure they at least know and could apply the minimum to perform the role of medical expert. Students also spend a fair amount of time on acquiring the competencies for the communicator role through the Clinical Skills courses. They are provided with concrete knowledge on how to perform the skills needed to be a good communicator, and the opportunities to practice these skills with simulated patients and preceptors, and are evaluated to perform the competencies. However, for the other physician roles, students are told the importance of these roles in lectures and left alone to explore these roles in communities with limited hours and reflect on their experiences with limited mentorship. These institutional practices on teaching all serve as tacit knowledge, through which medical students decide what and how to learn and how to spend their time and efforts in medical school. The dilemma is the knowledge and skills to do well in the other physician roles cannot be magically acquired; they require time and practice to master as well, just like the medical expert or communicator role. For the roles of medical expert (with science and clinical courses), communicator (with communication modules), and professional (with CoM’s focus on student professionalism and professionalism in professionals), students are required to “do”; however, for the other roles, students are only required to “know”.

The hidden curriculum that reveals students’ learning experiences and faculty’s teaching experiences with medical professionalism further reflects the inadequacy in this aspect of medical training. Students devalue the learning on medical professionalism as it becomes a
taken-for-granted assumption that the competencies in many non-medical expert physician roles are not essential to successfully completing medical school. This continues to be a challenge for the medical profession, which is facing pressures from the public to transform to a more collaborative and patient-centered approach to provide health care. Without significant restructuring of medical education, this could easily mean adding more content to the MD curriculum and adding more requirements for medical students, which is not sustainable.

The learning of professionalism and medical students’ PIF will be further discussed in the next chapter on clerkship learning opportunities. However, at the pre-clerkship level, little connection is drawn between professionalism and PIF. In the interviews with medical students, the discussion of professional identity in pre-clerkship mostly focuses on the transition from pre-meds to medical students and their primary identity as a learner. As the majority of learning happens in classrooms in pre-clerkship and students are not responsible for real patients’ care, most medical students do not think they have developed a professional identity in pre-clerkship (for medical students who were interviewed when they were in pre-clerkship) or at the end of pre-clerkship (for medical students who were interviewed when they were in clerkship). To avoid too much overlap in findings between the pre-clerkship learning and clerkship learning, results on professional identity and PIF will be discussed in the next chapter. The following sections present findings on the dimensions of a distinct identity of medical students and how their experiences in pre-clerkship contribute to that identity.

5.3 Transitioning to medical student identity

This section in this chapter addresses medical student identity while the professional identity of physicians or PIF in medical education will be discussed in the next chapter. Before we discuss professional identity or PIF, we need to first fully understand the identity of medical students. There are the distinct identities of medical students, residents, and physicians due to the hierarchical structure in medicine, the gradual increase in responsibility as people transition from medical students to residents, and eventually physicians, and the admission and evaluation processes that accompany these transitions. In medical education, especially pre-clerkship, though students are learning to be physicians, they are also learning to be medical students. The experiences of being a medical student, as a distinct identity, are rarely intensively documented in recent literature, nor is the impact of it on PIF in medicine. Before we begin to understand the factors that contribute to the formation of professional identity, we need to first understand what medical students bring to medical school and the construction of the identity of medical students.

In pre-clerkship, students have limited experiences with real patients and physicians in clinical settings; however, they still learn within a community with other medical students, which provides a form and channel of informal learning. Medical students carefully adjust their lives to meet the demands of medical school and demonstrate their commitment to medicine. Besides curriculum-arranged learning activities, students also tend to organize their extra-curricular activities, including volunteering, leadership, and research activities, to be medicine related. Frequently taking the same classes together, students, who also tend to do social activities
together, develop a close connection with their peers, especially those in their cohort. The CoM also intentionally tries to cultivate a sense of community for medical students, through supplying the identifiers (e.g., backpack) and hosting events during orientation (e.g., white coat ceremony) to welcome students to the college and the medical community and enhance the cohort impact. Medical students hold the primary identity as a learner in pre-clerkship and still have not earned the legitimacy to practice medicine. However, being accepted into medical school gives them the legitimate status to pursue medicine with the advantage and support that they have and slowly negotiate their status in the community of medical practice as they increasingly acquire more knowledge and skills. These elements all help students construct a medical student identity in pre-clerkship, which is the first step in their PIF. In the following sections, I describe these key findings in more detail.

5.3.1 Expectations for versus realities of medical school

Most students interviewed had a working understanding of what to expect in medical school and how to adjust to its high demands, often based on experiences of contacts who had completed medical school. There is also the peer mentorship program at the CoM, through which first-year medical students can talk to an upper-year medical student, who will walk them through what first year is like during the summer before medical school. Students expected it to be a lot of work – more demanding than undergraduate study and challenging academically at times. Despite this basic understanding, there were still some aspects they considered surprising or certain aspects they had an idea of but did not fully understand until experiencing it. This important transition from anticipating medical school to experiencing it personally is well captured in the following comment from a student:

Something someone said was like being in medical school is like looking both ways before you cross the street and then getting hit by an airplane. It feels like a different world a little bit. It feels sort of like being dropped into a brand new aquarium. (Student Participant #4)

This feeling of uncertainty when confronting a new and different world can pose challenges to some students.

Busy and stressful are two common words that students used to describe their medical school experiences. Even though students had an idea of the program being challenging academically, the volume of information still took some students by surprise. According to one student:

I think the amount we’ve learned is crazy. That’s, I think, something that’s come up a fair bit, even in discussion to peers on just the amount of knowledge we’ve learned in a very short amount of time. (Student Participant #2)

This feeling of being overwhelmed is, in part, due to the fact that the first semester is very intensive with courses with the 2+2 curriculum. This is well captured in the following comment:

Throughout my other studies I kind of was quite proud of myself for having a really balanced approach to things. To suddenly recognize that like okay I don’t know how to manage anymore, because this is so much more than I’m used to...probably that was the
most unexpected. I did sort of struggle through my first few months...in medical school a few months is like several tests and quite a lot of material. And it probably wasn’t until like mid-November that I kind of felt like I had handle on things. And not that I was anywhere near a balance, but that at least I could keep my head above water. (Student Participant #4)

The different style of teaching is another adjustment that students have to make at the beginning of medical school. According to one student:

Going into the first semester is just a completely new way of learning, a completely new way of approaching school. So not having a constant professor, but having lots of different professors teaching different courses or teaching different lectures. That was quite different as well. (Student Participant #3)

This taken-by-surprise and feeling the challenge could lead to students questioning whether they have what it takes to be in medical school. One student reflected on this:

Because in first year you’re super excited and you’re just really happy to be there and looking forward to everything and then you get into things and...you realize it’s really hard... I think it’s because most of the time the people that get into medical school are close to the top of their class, they are the smart ones and then you get into medical school and everyone is the smart one. So you feel like, well, all of these other people are really smart and what makes me so special and sometimes you feel like you are not doing as well as some of the people around you and you just feel like maybe there’s a mistake, maybe I shouldn’t actually be there. Sometimes you feel super overwhelmed so you kind of question whether or not you made the right decision. (Student Participant #13)

Faculty agreed that this imposter syndrome, reflected in students questioning “How did they (medical school) let me in? They made a mistake”, could be a very common experience for medical students.

Many students explained the process of feeling overwhelmed at the beginning and eventually adjusting. One student used a metaphor to describe this:

How I kind of explain it to people as of late is when you’re in it, it’s very overwhelming in the fact that you have so much material. It’s like drinking water out of a fire hydrant. You just can’t get it all. But you will eventually. It’s just overwhelming at first. But you look back at what you do in a month and it’s amazing what you’ve learned and what you’ve done. So that’s what kind of keeps me going I guess in medical school. (Student Participant #5)

One strategy that contributes to this adjustment is students switching from the undergraduate mentality of ‘I need to know everything’ to ‘I need to get by’. Coming to terms with the pass/fail system brings students the realization that “you need to know everything at some point but you do not need to kill yourself to get 90s in every test” (Student Participant #11). Another strategy is learning to prioritize with so many demands (courses and extracurricular activities) thrown at medical students. One student commented on this: “You really got to pick and choose your
battles and what you want to do if you want to continue to be afloat” (Student Participants #5). Students described their lives feeling more balanced (i.e. going to the gym again and having hobbies again) once they were more comfortable with the rhythm of medical school.

However, there are also students who expected the program to be harder. They differentiated between the program being challenging in the sense that it is time consuming and that it is difficult in learning, especially in pre-clerkship. According to one student:

It’s hard in the sense that it’s difficult time management wise. But in terms of curriculum material, it’s a lot of just memorization. My background is in (one of social science disciplines) so I’m used to a lot of deep thinking about issues and really delving into them and having deep discussions about that. However, medical school’s a lot of memorize, understand, regurgitate, which I was kind of taken aback by a little bit. I think the application is going to be more difficult in clerkship... It’s not easy in the sense that there’s a lot of work. It’s certainly not easy. It’s just the material isn’t very difficult. (Student Participant #11)

Even though students encounter the same structured curriculum, their experiences prior to medical school could impact how they approach medical school and how well they adjust to the expectations of medical school.

Students commented that there were also some positive surprises with regards to collegiality, the involvement in extracurricular activities, and the opportunity to have patient encounter from the beginning. One student discussed the feeling of community and collegiality:

I wasn’t really totally sure what to expect in terms of the collegiality between my classmates and me. And that’s been kind of a pleasant surprise. Just since the beginning...I guess the fact that we are in the same classes almost every day together aside from our small group sessions, gives us the opportunity to get to know each other more. And we do social events and there was an instant feeling of community, probably within the first couple months of being in med school. The sense of competitiveness from undergrad was no longer there because we’re in the program now and that kind of went away. (Student Participant #1)

One student specifically mentioned the collegiality on the Regina campus (though students all study on the Saskatoon campus in their first year of study, 40 students of the 100-student cohort are trained at the Regina campus starting second year):

I have a bit of a different experience in Regina compared to those in Saskatoon, in the fact that we have a smaller size of students. And there’s more hands-on and I feel like we’re a lot closer than those that are in Saskatoon. And I think I might be biased, but more willing to work together. (Student Participant #5)

With regards to the learning environment, students had mixed opinions. Some students felt the learning environment turned out to be more friendly than expected, which was a feeling more common among pre-clerkship participants. According to one student:
I think in general the reputation that medicine has is kind of like a cut-throat kind of deal. I think before medical school I thought preceptors would be a little bit harder on you, like have more expectations...not embarrass you but really put pressure on you. And that’s something I haven’t noticed. People teaching have actually been relatively kind. They understand you’re first year; you don’t know anything yet. (Student Participant #12)

However, some students did feel the need to perform, because of the constant assessments (exams, evaluations, and work done closely with peers and preceptors) from others. One pre-clerkship student reflected on the pressure of being observed:

But you’re being assessed by your peers. You’re being assessed by preceptors. You’re being assessed by people that you’ll be working with regularly. And so I don’t know if this is what lots of people felt, but I always felt sort of a pressure of people watching and observing me and I want to show that I am competent or that I need to learn something better. So in that sense, it’s very tiring because you’re constantly having to perform, if that makes sense. (Student Participant #7)

These examples, again, illustrate that students’ experiences in medical school can be quite different based on their prior experiences and how they approach medical school. They both, however, identify the impact of learning environment on students’ learning experiences, which is more prominent in clerkship.

A big component of extracurricular activities for medical students is to get involved with the SMSS and its associated student groups and committees. According to the SMSS website:

The SMSS is an organization ran by medical students, for medical students. The SMSS participates in advocating for student needs within the classroom, with the College, and within the community. Further, this organization provides numerous opportunities for students to gain external clinical experience, liaison with other organizations to promote student well-being, and engage the student body in events throughout the school year.

One student described the involvement with SMSS as a nice surprise and appreciated the opportunity to be able to advocate for themselves through the involvement with SMSS:

I didn’t really expect there to be as much extracurricular involvement with all the student groups and the SMSS. And I quickly realized that there’s a lot of advocacy for medical students. And lots of things that are done by the students for the students. And I was really impressed with that. And I soon got in on it myself and found it very rewarding. (Student Participant #1)

The SMSS currently has 24 student groups and committees listed on its website, which cover most specialties in medicine (e.g. Student Surgical Society) and other interest groups (e.g. Aboriginal, Rural and Remote Health Group). The opportunities are student-led and allow students the freedom to explore further their interest in medicine outside of the curriculum, with support from faculty and the College. For example, on the SMSS website, the U of S Ultrasound interest group is advertised to:
promote and teach clinician performed ultrasound (CPU) to medical students, to guide future clinical evaluation and treatment of patients. We seek to enhance student skills by providing hands-on probe time, expert multidisciplinary clinical guidance, and opportunities to learn how to integrate findings into clinical decision making.

Medical students’ close connection with peers and participation in extracurricular activities both extend their immediate learning environment with preceptors to a wider community.

Even though most participants indicated they had some expectations for medical school through their personal connections, it is important to note that some students did come to medical school without any previous expectations. According to one student:

Honestly I don’t really know what I expected or imagined. I had very little idea of what medicine was going to be because I knew nobody in the field. I didn’t do a lot of shadowing prior...I really had no concept of what it was going to be. It has all been one surprise after another. One learning process, one learning curve after another. (Student Participant #14)

One possible explanation for the comparably lower exposure is the changing requirements of the admission to the MD program and the intention to accept more students from different social backgrounds. The CoM is seeking to accept more students with non-traditional academic backgrounds like social science or humanities and students with lower social and economic status. There potentially will be a higher percentage of students who are less familiar with the culture of medicine, and the requirements and expectations of the program because they have had less previous exposure to the medical field. The CoM currently has a Diversity and Social Accountability Admissions Program (DSAAP), which has 6 seats available each year. To be eligible for the DSAAP, students have to answer yes to the question “If the average gross family income over the past 5 years is below the $80000?”. The CoM also has an Indigenous Admissions Pathway, which “is designed to support the growing number of Indigenous people choosing to become doctors in Saskatchewan” (CoM, 2020). According to the CoM website: “ten percent [10 seats] of the positions available in the MD degree program each year are specifically for applicants of Indigenous ancestry.” Besides these two programs, the CoM also has other resources in place to support the transition into the new identity of medical students. These are centrally located within the CoM Student Services, which is composed of Indigenous Student Services, Office of Student Affairs, and Office of Career Advising & Mentorship.

The transition from pre-meds to medical students can be a challenging process, especially in the first term of medical school, when students’ experiences are defined as busy and stressful with tight schedules and constant evaluations. Even though most students had clear expectations for medical school, the intensity of the curriculum still took some by surprise and required a high degree of time management and several months of adjustment for them to find a new balance. The pre-clerkship learning experience was characterized by most students as a lot of memorization of content, the pressure to manage various demands with limited time, a supportive learning environment, and collegial relationship with peers. Besides the in-school demands with the MD curriculum, there are some external influences that impact the identity of medical students. The next section addresses these influences.
5.3.2 Identifiers, cohort impact, and outsiders’ opinions

Medical school across Canada and around the world is usually associated with a post-secondary institution; at the same time, medical school is an independent entity separated from the post-secondary institution with its own structure, admission process, and policies. One student participant (#2) reflected on this unique position that medical school has: “Because everything, it seems, in Medicine is all within our college. I don’t really interact with the rest of the university.”

Medical students are given some identifiers (backpacks and water bottles) by the Canadian Medical Association with the intention that they could recognize each other at school or conferences, with each cohort having the backpack of a different colour with the graduation year printed. At the same time, the backpacks make it very easy for others on campus to recognize medical students. In the interviews, medical students regarded the backpack as a very contentious topic, which was reflected in that some students refused to wear it and some wore it all the time. Students, however, generally recognize the significance of it beyond “simply a backpack” or “a nice thing to have”, as illustrated by one student’s comment: “It’s not part of the curriculum. But it’s endorsed by the CMA, so it’s a Canada-wide form of social control and identity formation” (Student Participant #15).

Some students consider the backpack a good communication tool to connect with medical students from other cohorts. One student explained the different feelings about the backpack before and in medical school:

Before I was in medicine when I saw medical students wearing the bag I was like, ‘Oh, this is so obnoxious. Like why do they all have to walk around showing everyone they’re medical students?’ Part of it is probably just jealousy, like I wanted to be there as well. And so when I got into medical school I didn’t wear the bag for a while. But then I realized, depending on how you look at it… it’s also a really good communication tool. When I wear it, other medical students will notice that you’re also in their or are going to be in their shoes. And then you get this smile, you get a glance. In that sense it builds relationships but to everyone else it’s definitely an exclusionary kind of thing. I’m sure we’re conditioned to feel special probably…. (Student Participant #12)

The above example demonstrate that the backpack is not just an essential for school or a way to communicate with other students – it carries an identity that comes with the feeling of pride and being special as a medical student. Like the backpacks and water bottles, the stethoscope also has a similar symbolic meaning to medical students, even though they barely use it in first year. They all identify that medical students belong to a community that has authority and that people respect.

Students also recognize that because of the easy association of the backpack with medical students, it serves a social control function that when wearing the backpack they represent the larger medical community. The following example reflects this:

I’ve been with a group of us before and I had somebody come up to us and say, ‘You guys must be medical students’… So clearly even if we maybe aren’t fully identifying with it,
other people know it. So in a sense you’re essentially representing the College when you’re wearing it, that you are identifying yourself as medical students so behave accordingly. So I think there is some identification aspect to it for sure. (Student Participant #2)

Some students, however, are resentful of the backpack because of the fact that people can easily identify medical students through the backpack and expect certain behaviours from them. One student provided an example of the turning point from wearing it daily to refusing to wear it:

Myself and four other medical students were walking by Place Riel, and I was the only one that was wearing the backpack that day. And there was a charity booth that was selling something for charity. And the person at the table was soliciting everybody walking by, ‘Hey come help out our cause’. And then she spotted me with my backpack and she said, ‘Hey, you’re a medical student, you should…’, – and immediately associated me with a behaviour…should be donating to this charity. I felt a little bit resentful towards it…so I haven’t worn the backpack since then. (Student Participant #15)

The identification of the identifiers of medical students – whether medical students identify with them or to what extent they identify with them – can be different for medical students with different backgrounds. For students who are more ‘mature’ when entering medical school, manifested by either having work experience or having established home life, their identities as a medical student revolve less around these identifiers or others’ expectations of them but more around their own expectations.

Besides the impact of identifiers on the construction of the identity of medical students, the cohort impact is another contributor. One faculty member described the identity of medical students as manifested by the cohort identity:

…from the beginning of first year and I think this is probably true for most of our students, they do start thinking about themselves differently from what they were before. Not necessarily do they start thinking about themselves as a physician. But they’re a member of a single cohort as opposed to in undergraduate they’re with different students from different classes all the time. So there’s that cohort identity as this class, this first year class. (Faculty Participant #7)

Faculty consider the cohort identity to be the intended result. The identifiers – backpacks and water bottles – make students feel welcomed and give them a sense of already being with the college and profession. The representation of the College and the profession could also in a positive way bring a sense of belonging and community to the members within. Some of the activities that the CoM has, including the white coat ceremony, also help set the stage and give students a sense of fellowship and community by having them all together at the start of first year.

The cohort impact was also discussed by many students. There is a strong sense of community among medical students as they are generally in class (large group or small groups) eight hours a day, five days a week, and take most classes together. Compared to other programs in post-
secondary education, medicine, as other professional training programs, is quite unique. One year of class, as a cohort, defines social norms among themselves. As one student reflected:

You pick up on what’s appropriate. And then that becomes a social norm within the class...it’s mostly implicit I’d say. You just learn from watching how other people interact on what’s appropriate and what isn’t...you see these people so often. I’d say there are lots of things that I learn, like what not to do from peers. Because we’re all learning and sometimes you don’t know what’s appropriate yet or where the boundaries are...you’ve never had an opportunity to test that boundary....we’re all in the same boat and not everyone has to make the same mistake. And then at the same time, learning what to do because there’re a lot of really good people in my program...looking at others and recognizing their strength is just as important. (Student Participant #7)

The cohort impact and the sense of community also extend beyond the school environment and penetrate medical students’ social life. One student described how the identity of medical students took over who they were because of this cohort effect:

It’s almost like being in high school again where all your friends are medical students. And even when we go out to hang out, when we talk about things, often there’ll be a lot of little medical stuff coming back in. And it’s stuff that we’re all comfortable. We know that’s where we can all connect with each other on. And so it becomes a topic that everyone’s always chatting about. (Student Participant #12)

Because of the peer influence and the medical community that they are so immersed in, medicine becomes an encompassing part of medical students’ identity.

How medical students are treated by people who are outside of medicine, whether they are close families or friends, people they know, or simply strangers, impacts how they think of themselves and their identity of medical students as well. From interactions with others, medical students learn that they, as a group, are positively looked upon by many in society and the status of being a medical student could easily open up possibilities for them. One student used the metaphor of “the sky is the limit” to describe the opportunities that come with being a medical student, earning the “extra support”:

The nice thing about being a medical student is I feel like I could have a seat at any table. And if there was, for example, a research project I was interested in or a new idea, I feel like I would be listened to. And people whether in the college or outside of the college would be willing to hear what I have to say or willing to help me out or encourage me along my path. And so I think that’s been a unique experience in my life in that being a medical student, you’re positively looked upon for the most part...so when interacting with individuals, it gives you some extra support. (Student Participant #8)

There is a very clear end goal for the MD program, like any other professional training, which is to become a physician. Others’ expectations for medical students, especially from close families and friends, can also bring pressures to them – the worry of the repercussions of failing medical school. According to one student:
...especially where people around you now expect you to be a doctor. Like once you’re in medical school, it’s not a question anymore. It’s almost assumed that you will become a doctor. And that’s pressure. And I’ve been much more aware of that pressure. (Student Participant #12)

Students recognize that there can sometimes be a contrast between how medical students see themselves and how others outside of medicine see them. Even though students do not feel confident with their knowledge base (especially during pre-clerkship where there is not a lot of knowledge application), people around them might see it differently. This is well demonstrated in the following example:

Despite you just realized how much there is to learn and how much you don’t know, people outside...particularly I noticed in my family but other people said friends too, began to treat me as more of an expert. And it was an interesting disconnect...like I’m learning so much and while I’m learning I know that there is so much more I need to learn. But having even just learned the little bit that I have does put me in a different space of knowledge than other people. (Student Participant #4)

This feeling of disconnect is further enhanced, and to some extent, encouraged by people in medicine. Students are made aware of their presentation of self, especially when they are with patients and that they represent the health care team or the medical profession. The student participant quoted above discussed being reminded of “the energy you give off to people”:

The preceptor said, ‘You know, you got to stage smile. You got to have that whatever show to have patients feel comfortable in your abilities.’ And it was really surprising because I don’t remotely feel confident in my abilities yet. You know, I’ve only been doing this for eight months. And a lot of it is still very, very new and very foreign. So yeah, the idea that even if you don’t really trust yourself and your own abilities, you have to act as though you do to help other people trust your abilities. (Student Participant #4)

Medical students’ experiences in medical school, which help construct the identity of medical students, are impacted not only by people in medicine (preceptors and peers) but also by people outside of medicine and their interactions with them.

The identifiers of medical students that distinguish them from other students on campus, the cohort impact, and the status that society gives to medical students, all contribute to a unique identity of medical students, which comes with not only pride and opportunities, but also discomfort and pressures. The explicit and implicit expectations influence how they conduct themselves and present the identity of medical students. The following section discusses the impact of the expectations from medical school on medical students’ identity.

5.3.3 Expectations from medical school and the profession of medicine

As mentioned earlier, medical students were asked to treat medical school as a full-time job. Students realize there are some aspects of life that they have to sacrifice because of the career that they choose and indicated that they had less time to dedicate to other interests. Being a medical student can easily become “all about medicine” due to the tight schedule of the MD
program and the fast turnaround on different sections of knowledge. Some students discussed the “all about medicine” as one of the hidden rules and expectations of medicine. It might be presented as a suggestion to go above and beyond the curriculum to be successful in medical school; however, it is considered by many students as “the somewhat unspoken need”. According to one student:

...to be well-connected and to engage in medically-related extra-curriculars outside of the actual work and the actual school-allotted hours... That information is relayed as more so as a suggestion. However, when you actually look at the importance placed upon networking and that investment in the extra-curricular side of med school, it’s not just a suggested benefit; it’s almost a pre-requisite to success. And even though no one says you must, it is strongly encouraged but in such a subtle way that a person could almost choose to ignore...which could incidentally lead to disadvantage down the road. Because it isn’t explicitly stated. No one is straightforward with this kind of stuff. (Student Participant #14)

These hidden and unspoken rules are usually transmitted by close friends or families who are in medicine, which could potentially disadvantage students who do not have contacts that can provide such knowledge.

The unique nature of the field of medicine, dealing with life and death issues and encountering people in some of their most difficult situations, requires certain characteristics of people working in the field, which is also true for medical students. One student discussed the value of perseverance in medical training:

Being a medical student, I think it means to have a great value in perseverance because it’s a long, very tiring program...and you’re dealing with very personal and sometimes traumatic situations... But it’s something that you need to be very stoic with, if that makes sense? Like you’re dealing with people who are in emergency for something scary...maybe they’re having a heart attack. And you have to be there to learn from them, but you also can’t be freaking out because you don’t know what to do yet. So I think you have to be strong and you have to be able to withstand a lot of stress without making it show. (Student Participant #7)

To meet medical school’s high expectations, students hold on to the positive aspects of being in medical school and reflect on the journey that led to medical school. The feeling of appreciation for where they are is well reflected in the following example:

I applied after my second, third, and fourth year so I had to try three times before I got in. Thinking back on that makes myself feel better because I worked really hard to get into medicine. I should still be excited because there are a lot of people who wish they were in my position...reminding myself that I really did want it usually helps me to be happier in my current position as stressful as it is. (Student Participant #13)

Similar to the co-existence of responsibilities and high social status for physicians, medical students struggle with the high demands of medical school but also experience the status of
working in the medical field. One student discussed feeling privileged through experiences working with patients:

I feel like it’s an honour in a sense because you are privileged to know things about people that they are not willing to share with other people so that you can help them. And the things that they share and the things that you do are very personal – it’s a privilege to know these things and to be able to help these people in that respect. (Student Participant #5)

Students are gradually introduced to the expectations of being a medical student and future physician, which are delivered both explicitly and implicitly. These expectations slowly, but in a very concrete and detailed way, change how medical students organize their daily study and life beyond medical school. Being a professional medical student is the first step in becoming a member of the medical profession.

5.3.4 The primary identity as a learner

The most significant factor that distinguishes the identity of medical students from the identity of physicians is the students’ lack of knowledge and skills and lack of experience in the application of the knowledge and skills. This, to a large extent, contributes to medical students being at the bottom of the hierarchy in the medical profession and defines their primary identity in medical school as learners. Even though they are seen as future physicians, medical students are aware that they are only at the beginning of the journey of becoming physicians. This lack of knowledge and skills, constant evaluations, and the pressure to know more in less time bring motivation and anxiety to students at the same time.

Faculty generally acknowledge that medical students are a keen group – “type A” (described as eager to learn, competitive, and always ready to take on challenges), as they like to call them. As one faculty explained:

...the med students for the most part are very acutely aware that they don’t know a lot. They don’t necessarily know what they don’t know but they’re very acutely aware of the fact that they have all this stuff that they don’t know but they want to. It really shows a keen sense of responsibility. They all want to learn about how to do this physical exam, how to properly manage, what the treatment plan is, what medication, what I should be using in this exact situation. (Faculty Participant #6)

As this is a common feeling for medical students, especially first-year students, they adjust their expectations for themselves and make peace with the fact that medicine is a life-long learning process. One student described this approach:

I think any time you just come across knowledge that you’re like, ‘Okay I don’t know what that is and I don’t remember learning about it’, then you know either it’s something you will learn in the next year or those are things that you’ll learn in clerkship, you’ll learn in residency. I approach it as there are steps and you’ll pick some of those things up along the way. (Student Participant #12)
Medical students are expected the same level of professionalism; however, their status in medical school depends primarily on being a learner. One student discussed the unique position of being a learner in the medical field:

Being a medical student, I think there’s student part of it, I think learning the profession. It’s a unique space where you won’t get in too much trouble for not knowing. It’s a very exciting space of learning where you can ask lots of questions... There are all these people who have all this experience, who want to teach you all these things so that in a few decades you sort of become their peers and take on the same roles. (Student Participant #12)

Even though students in medicine typically have the eagerness to demonstrate competency and confidence, they also realize that knowing when to acknowledge weakness and being humble is equally important. As one student illustrated this:

There is also I think a responsibility of students to admit when we don’t know something or don’t feel confident. Because if we go into a situation and we don’t know what we’re doing, that can cause more harm. And so I think there’s an equal responsibility for us to be humble, even when we want to show that we know things. And maybe the outcome may not be what we want it to be. We may not get the best review. I think in the end it’s more beneficial if we can humble ourselves a little bit to acknowledge our weakness. (Student Participant #1)

One student participant (#4) described this as: “being very cautious of carrying a confidence that I haven’t earned yet.”

5.3.5 Summary of 5.3

The identity of medical students in pre-clerkship is very distinct when they make the transition from pre-meds to medical students. Even though they have a fair amount of knowledge of what medical training would be, the transition is still a challenging and stressful experience. Both the cohort and external impact contribute to their construction of the medical student identity. In managing the high demands of medical training, medical students hold on to the privileged feeling of studying in medical school and the bright future career that it promises. The medical student identity is important to the development of a professional identity because it gives medical students access to the community of the medical profession. They are trained within that community, which gradually introduces them to different aspects of expectations, and go through the continuum of development. Building a professional medical student identity is the first and a very important step in the PIF in medical education.

The relationship between professionalism and professional identity or PIF is rarely drawn in pre-clerkship curriculum. While the student professionalism, professionalism in professionals, and medical professionalism all exist in both the formal curriculum and informal curriculum, little focus is put on professional identity at the pre-clerkship level. The next chapter – the second chapter of findings – will move on to discuss students’ learning on professionalism and
professional identity in clerkship, with specific focus on medical students’ changed understanding of medical professionalism and PIF.
CHAPTER 6 FINDINGS PART 2 – PERFORMING PROFESSIONALISM AND DEVELOPING PROFESSIONAL IDENTITY IN CLERKSHIP

6.1 Introduction

Clerkship is a significant component of medical training, in which classroom training is extended through intensive on-site practice and students work under the supervision of faculty and other health care providers to care for patients in different health care settings. Participants who are clerkship students discussed their experiences, speaking about how these experiences contributed to their changed understanding of medical professionalism and their roles as physicians, and their PIF. This chapter adds important dynamics of clerkship to the overall map of students’ learning with professionalism and PIF in medical education. It briefly introduces the formal curriculum in clerkship but, more importantly, maps the learning mechanisms on professionalism and PIF in clerkship and explores students’ experiences with them. It also emphasizes the process of students developing an understanding of medical professionalism that is more realistic and their individuality and agency in PIF.

This chapter specifically situates medical students’ learning in the community of medical practice, which provides the foundation for knowledge sharing, and answers the research question of how medical students develop professional identities. Students’ intense immersion in the community gives them access to observe and interact with experts in clinical settings. Through peripheral participation, students apply the abstract knowledge and skills that they acquire in pre-clerkship, moving from simple and low-risk to complex tasks and continuing to work on the identified knowledge and skills gaps. More importantly, students learn by providing direct patient care in clerkship, which allows them to identify with the feeling of being able to help patients and the uncertain and complicated aspects of medicine and health care. These elements contribute to students identifying with the experiences of physicians and associating with the side of physicians.

Medical students need to perform medical professionalism and develop a changed and more realistic understanding of medical professionalism to form a professional identity. In clerkship, students experience steep learning curves through the rotation-based model and frequently encounter new patients and case scenarios. This not only allows them to experience the various career pathways that medicine offers but also forces them to continuously rethink and modify their previous perspectives on professionalism and physician roles. However, medical students work and learn in a complex environment that has competing priorities, especially between competent and caring, the medical expert role and non-medical expert roles, and standardization and individuality. The clerkship environment might not always model the ideals preached in the formal and, sometimes, the informal curriculum. Therefore, students might not have the opportunities to develop or apply the knowledge and skills to perform the non-medical expert roles or have the motivation to advocate for change. This could further contribute to the status quo in how health care is provided. Overall, this chapter analyzes learning in clerkship as a social practice, highlighting the impact of learning environment, interactions, participation, and power relations on students’ learning experiences.
Medical students commented that the hands-on experiences in clerkship greatly impacted their learning of professionalism and PIF in medicine, particularly compared to classroom teaching of professionalism or the limited time of experiential learning on this topic in pre-clerkship. Pre-clerkship is about knowing the boundaries and acquiring the knowledge and the tools associated with medical practice, while clerkship is about applying them in real-life situations, with some level of supervision. As medical students are responsible for providing some direct patient care, an important shift from pre-clerkship to clerkship is the focus shift from acquiring knowledge on a topic or disease, or passing an exam to the care provided to patients. The priority has to be refocused from emphasis on abstract knowledge to practical activity based on the environment or the situation.

The following comment from one student who when interviewed was soon to start clerkship illustrates the difference between learning about the ideals of professionalism in the classroom and actually practicing them through interactions with staff and patients:

Because right now we’ve learned a lot of didactic things about professionalism and learned that it’s something that we need to do in all our interactions. But we haven’t had to apply that lesson yet. And I think once we start clerkship and we’re humbled and humiliated – because those words are quite similar – I think that people will internalize it a little more. (Student Participant #11)

In clerkship students come to realize that there is a wide array of skills and responsibilities that need their attention besides learning clinical knowledge, which is the primary focus of pre-clerkship. One student provided a general overview of clerkship and highlighted the “learn by doing” part:

...the clerkship curriculum is kind of where everything starts to come together. You learn about how to synthesize all the different bits of information and apply them in a clinical setting to a real patient, which is complicated and very interesting because I find that not a lot of patients actually conform with the information that you learn about in pre-clerkship. And so it’s about how do you modify and how do you apply it to manage someone. And then you also learn a lot about how to be a physician and how to run a practice, how to deal with people...you’re kind of in the process of learning how to become a doctor...not only in learning and applying clinical medicine, but also managing patients and managing relationships, interpersonal stuff. So busy, not so much time for reading. But you learn by doing. (Student Participant #10)

In the rest of this chapter, I first describe the CoM’s formal curriculum in clerkship and students’ experiences with the learning mechanisms in clerkship that contribute to their learning of medical professionalism and PIF, including role modelling, patient encounter, fitting into the environment, self-directed learning and feedback, and curriculum gap. This is followed by describing participants’ understanding of medical professionalism and physician roles. I then move on to describe the importance of a professional identity in medicine and how students form their professional identity in medical school. Lastly, I present data on participants’
discussion of how medical school could better facilitate students’ learning of professionalism and PIF.

6.2 Summary of the formal curriculum in clerkship

Besides SinMS III, which was discussed in the previous chapter as one of the SinMS series, the CoM’s formal curriculum in clerkship includes Core Clinical Rotations (MEDC 307 with 8 mandatory rotations including Anesthesia and Emergency Medicine; Emergency Medicine; Family Medicine; Internal Medicine; Obstetrics and Gynecology; Pediatrics; Psychiatry; and Surgery), Selective Clinical Rotations (MEDC 309) for Year 3 medical students, and Elective Clinical Rotations (MEDC 407) for Year 4 medical students. Starting in 2018, students at the CoM had the option to choose the Saskatchewan Longitudinal Integrated Clerkship (SLIC, MEDC 306 with Meadow Lake and Estevan as two program sites), the successful completion of which is equivalent to successful completion of the MEDC 307 course.

Selected Topics in Medicine (MEDC 308) is another course for Year 3 medical students. According to the course syllabus, the course “consists of topics selected to address the general knowledge base required for completing clinical rotations and to ensure students attain a broad basis of learning that will help them as physicians” and includes two major parts: professional development, wellness and career advising and mentoring sessions; and selected topics in medicine (abdominal pain in children, acute pain management etc.). Preparation for Residency (MEDC 409), the other course for Year 4 medical students, has as its goal “to review the accumulated knowledge obtained over the course of the four years of medical school, focus on the clinical application, and ingrain the principles of physician wellness and development.” These two courses, which are different from the main structure of clerkship, are largely classroom- and lecture-based and were barely mentioned by participants in the interviews. Therefore, this chapter focuses on the rotation-based learning experiences in clerkship.

According to the MEDC 307 syllabus:

The clinical clerkship allows students to apply basic knowledge and skills acquired in the first 2 years of medical school, in the clinical setting. Students will work under the supervision of clinical faculty and other health care providers to care for patients... Students will have the opportunity to take graduated responsibility for patient care in a supportive setting where a balance will be established between time for service and learning. Students will have the chance to follow patients over time, and in different settings, thus experiencing relationship and responsibility of care.

The overall course objectives are also identified in the syllabus to align with the program learning objectives that consist of roles as medical expert, communicator, collaborator, leader, health advocate, scholar, and professional, each elaborated with more detailed bullet points. Many expected elements of professionalism are listed either under ‘professional’ or other learning objectives. For SLIC students, the course objectives are listed as the same as the ones in MEDC 307 syllabus. However, it is also stated that:
SLIC students will work closely with one primary preceptor gaining continuity relationships with patients and faculty over time in a continuous learning community... SLIC students will experience a learning environment that provides comprehensive care of patients over time and meet the clerkship year’s core objectives across multiple disciplines simultaneously in a one-on-one teaching environment. Students will create a personalized learning plan and schedule with their primary preceptor and work in multiple settings to achieve their course objectives. (MEDC 306 syllabus)

The MEDC 309 course “is a 6-week rotation consisting of 4 weeks of medicine subspecialties and 2 weeks of surgery subspecialties” (MEDC 309 syllabus), the overall course objectives of which are a combination of detailed bullet points without listing learning objectives for each rotation. According to the MEDC 309 syllabus:

This course is designed to allow medical students to further pursue their own interests and to individualize elective experiences in keeping with their individual professional goals. Knowledge, skills, and attitudes are further developed in a critical context selected by students.

The overall course objectives are listed in the same structure as MEDC 306 and 307 with variation for each of the program learning objectives. For MEDC 407, which provides similar elective learning opportunities for Year 4 medical students, they must complete 14 weeks of electives.

Independent learning is emphasized in clerkship, being listed as a separate section across the clerkship syllabi of MEDC 306, 307, and 309. For example, the following is stated in the MEDC 307 syllabus:

Please note, students are encouraged and expected to enhance and expand their knowledge of core rotation objectives through self-directed learning, consistent with your pre-clerkship self-directed learning activity. This can be done through an identification, analysis and synthesis of credible information sources, a sharing of knowledge with peers and/or instructors, and application of new knowledge within the core rotations, and seeking out feedback from their peers and instructors regarding their new knowledge and skills.

For SLIC students, it is stated in the MEDC 306 syllabus that: “Students participating in the SLIC need to be self-directed and independent learners. SLIC students are expected to know the course objectives and seek out opportunities to fulfill these objectives throughout their clerkship.”

One important intention of clerkship is to give medical students the opportunities to explore the different specialities in medicine. The formal curriculum in clerkship emphasizes self-directed learning and feedback, which, to a great extent, is dependent on mentorship and working relations between learners and preceptors. This leaves great potential for students’ growths in clerkship but may also limit students’ development, depending on the learning environment, students’ motivation, and preceptors’ interest in teaching and mentoring. The next section describes the learning mechanisms related to professionalism and professional identity in clerkship and students’ experiences with them.
6.3 Learning mechanisms related to professionalism and professional identity in clerkship and students’ experiences

The following sections are organized according to the learning mechanisms in clerkship identified by medical students to have made an impact on their learning of medical professionalism and PIF. As explained in the research methodology earlier, participant observation was not feasible for clerkship for this study. The following description and analysis of students’ learning experiences in clerkship came not from my direct observation but from the interview data with medical students and faculty. The relatively unstructured nature of clerkship also means there is a high level of complexity of curriculum definition and variation in students’ individual learning experiences, especially when self-directed learning is encouraged and expected. I have therefore decided not to distinguish between the informal curriculum and hidden curriculum in presenting the results in this section. Instead, I present collectively the content on students’ learning of professionalism and formation of professional identity in clerkship. The four learning mechanisms included in this section are: role modelling, patient encounter, fitting into the environment (learning in different specialties and learning within the hierarchy), and self-directed learning and feedback. Curriculum gap is listed as a separate theme, in which the gaps between the intended teaching and unintended consequences are revealed and discussed.

6.3.1 Role modelling

Role modelling is a very significant mechanism of understanding professionalism and developing professional identity for medical students. Being on the ward or in clinics gives them consistent access to role modelling, which is a form of informal learning that delivers tacit knowledge of how to apply the abstract knowledge and skills. Tacit knowledge could either support or contradict the formal curriculum. In clerkship, students are immersed in professional and unprofessional behaviours, which are related to not only professionalism on a superficial level but also medical professionalism that is core to what kind of doctor they want to be in the future. In the following example, one student described how the day-to-day routine and the observation that comes with it could make a big difference:

...now that clerkship...certainly a lot of the professional identity recognition has come about through the day-to-day routine. I guess an informal sense, but still within the curriculum itself, just informally...seeing how others perform or interact at the physician level...how they interact with each other, how they interact with learners like a student or a resident, how they interact with the other health care professionals. You take in and soak up as much as you can, and then that observation plays a large role in...how much my perspective has changed in terms of what’s professionalism to me, with the experience of clerkship itself. (Student Participant #16)

One key element of professionalism that students observe modelled for them in clerkship is patient-centered care, which is a big focus of M&S courses in pre-clerkship. General guidelines are provided in those lectures; however, it is in clerkship that students observe how it is provided to real patients in real situations, which come with competing priorities and can make it very
difficult to practice patient-centered care. Students discussed their observation of physicians who demonstrate patient-centered care, which contributes to them considering it one element of medical professionalism. One student described the importance of listening to patients and acknowledging their concerns:

I’m kind of seeing doctors that I feel are professional like when they don’t dismiss patients concerns, just because they are not relevant. Like I understand that doctors are busy but I have definitely seen doctors who are very busy, have a patient ask them a question and they are like, ‘Oh yeah, I’ll ask your nurse about that in just a second here’, whereas other ones kind of just like, ‘Oh well, that’s not important’. And even if it’s not really something that’s important just acknowledging it because I think a lot of the time patients just feel they need to be heard. (Student Participant #13)

Another student discussed a very concrete behaviour that was not a bullet point in guidelines on patient-centered care but to the student was a real definite example of that:

Sometimes we have amazing preceptors. Like one of the first few preceptors last year — I’ve never even met anyone who’s as professional as he was. When a patient changes in the room, once we step out he stands in front of the door. And he told us to do this wherever we go. He’s like, ‘If you step away and someone happened to walk in that room, now that patient’s privacy is violated’. Like all these little things…he was like so specific about making sure the patient was well taken care of. (Student Participant #12)

These concrete behaviors that students observe are more meaningful and have a bigger impact on their internalization of medical professionalism than the abstract principles listed in policies and lecture notes.

What is unique about clerkship is that medical students not only just observe, which is what happens with shadowing in pre-clerkship, but they also mimic preceptors’ behaviours. One way students internalize professionalism is through mimicking what they observe and resonate with. Even though no clear guidance is given on how to work in clerkship, students slowly pick up and try to meet the expectations by observing and mimicking those who are doing what they will do in the future. One student described this approach, noting that the content of mimicking could be as big as work ethic and as small as how to take notes:

...gen surg (general surgery)...just their (preceptors’) work ethic. Like they are busy. They barely sit down for lunch. They’re always following up on lab results or imaging. They’re just continually keeping that ball rolling. They don’t let pieces fall. So I think mimicking that work ethic. I didn’t sit down unless they sat down because I felt like I also had work to do. For pediatrics, their notes that they get us to take are very extensive, like when we do rounding in the morning...so making a very conscious effort to make sure all your stuff was tidy and clean before you left... Presenting...the way you present a patient, every discipline does it a little bit differently. So kind of watching and listening the way they do it and then try to do the same when you present. (Student Participant #6)
Another approach through which students learn professionalism is observing and reflecting on unprofessional behaviours. As described earlier in the literature review chapter, literature in medical education has generally identified unprofessional behaviour as a counterproductive force in medical students’ learning of professionalism. However, students commented in the interviews that on most occasions they were able to recognize the unprofessional behaviours and consciously took efforts to avoid copying those behaviours. For example, being late was identified by students as a common unprofessional behaviour by faculty. However, observing preceptors being late will not be used as an excuse by students to lower their standards for time management. Students also reflected on their general approach when observing unprofessional behaviours, not only on whether they would mimic the behaviour but also on whether they would consider reporting the behaviours or raising concerns. According to one student:

I think the first thing I try and think about is who it’s affecting. If it’s affecting themselves, kind of one of those things you just let it happen, cause they’re not only adults, but also the professionals that from a learner perspective it’s not really up to us...just in the hierarchy of things, up to us to say anything. But I certainly try to recognize what I would have done differently, or how to avoid acting that way, or portraying that behaviour. (Student Participant #16)

Even though students can, on most occasions, recognize and avoid repeating the observed unprofessional behaviours, the hierarchy referred to by the student is one of the reasons why sometimes students are not able to “do the right thing”. Students feel the pressure to fit in the environment, which is a valid and more urgent concern for them compared to raising issues about or flagging preceptors’ unprofessional behaviours.

Faculty participants in the study are aware of the vulnerable position that students are in during clerkship. One faculty commented on this:

Very often students will be able to identify what they think the right thing to do would be but most of them would say ‘But I wouldn’t do it because of repercussions and recrimination...it makes relationship tense’. So there’s knowing what to do and there’s actually figuring out how to do that in a way that preserves their...everybody’s dignity and safety. (Faculty Participant #1)

The concern and even fear on students’ side is well captured by the faculty member’s use of words with repercussions and safety. The following chain of quotes on the culture of talking badly about patients on internal medicine rotation from one clerkship student illustrates students’ recognition of unprofessional behaviours, the fear of raising concerns, and the strategies they adopt to keep themselves safe and fit into the environment. According to the student:

So there are certain physicians that I have worked with who always talk poorly about their patients behind their back in rounds or whatever they’ll complain about a patient. And they were professional with them when they saw the patient but then just say how stupid the patient is later on. That kind of really brought that up for me and you’re kind of like well I should try not to talk about them meanly. (Student Participant #13)

When asked whether she has raised the concerns to others, the student responded:
I haven’t...because I haven’t felt that they have been a big enough deal to say anything. Even if...they were a big deal I’m not sure if I would have been able to tell the preceptor, I might have had to go to the administration or the college or something instead because it’s so complicated with the hierarchy with the medical students, residents, attendings and how they are doing you evaluations and how that may do you harms eventually. (Student Participant #13)

When asked about whether she felt the pressure to join the conversations when preceptors talk poorly about patients, the student responded: “Yes, absolutely and I have on several occasions...whether just by not saying anything or by actually adding in a comment here or there or even just laughing at someone’s jokes.” The student further commented on how the work environment on the ward creates a very counterproductive learning environment for students:

It’s interesting because I had several residents on internal medicine who told me not to get sucked into the pessimistic culture of the internal medicine ward. I could see why it would be so hard to not, because it’s how everyone talks and how pessimistic everyone is about patient care, especially frequent flyer patients. It’s nice to get the advice but it was really difficult because they didn’t do a very good job of it themselves...they weren’t helping at all. (Student Participant #13)

The above two examples of unprofessional behaviours demonstrate that there are certain aspects of professionalism, negative examples of which can be easily disengaged from by students (e.g., being late), that depends heavily on students to achieve. However, there are certain aspects of professionalism, negative examples of which can be internalized as ‘acceptable’ by students (e.g., talking badly about patients when they cannot hear), that depends heavily on preceptors to model.

Role modelling is a significant component of students’ learning due to the nature of medical training and a very powerful channel of students’ development of professionalism and PIF. Some of the crucial aspects of medical professionalism (e.g., patient-centered care) need to be modelled and realized through concrete examples in clerkship instead of preaching for students to consider them as required competencies of physicians. Faculty need to be aware of the fact that they are being observed and mimicked, and their behaviours have enormous impact on students, especially with them being at the top and medical students at the bottom of the medical hierarchy. Although this relationship is rarely discussed between the two parties, its exitance is evident and guides everyone’s daily interactions. A related learning mechanism “fitting into the environment” will be discussed later in 6.3.3 while the next section addresses students’ encounters with patients in clerkship.

6.3.2 Patient encounter

Patient encounter is another significant contributing factor to students’ learning of professionalism and PIF in clerkship. Compared to volunteer or simulated patients in the course Clinical Skills in pre-clerkship, students see real patients in clerkship and provide patient care under supervision. The real environment gives them a sense of responsibility and a more realistic
understanding of physician roles. One student described the impact that real patients make on their learning experiences in the following example:

It seems to make a difference when we’re in the hospital or we’re at a clinic and it was a real patient. I think that elevates the learning experiences. Because it’s different reading or having a lecture told that patients are sick and they don’t feel well and they might be upset because they’re in pain... But reading that is much different than seeing a patient who is sick and in pain and not doing well. And they’re not responding to you the best because they’re sick and in pain. So actually experiencing it I think is the best way of learning. (Student Participant #2)

Working with patients allows students to see a range of intangible skills that play a role in good patient care. Furthermore, being able to help patients as a member of the health care team also gives students a sense of fulfillment that contributes to their professional identity. Students move a step further in their PIF and negotiate their identity in the medical community by performing the work of physicians as active members of the health care team.

Many students described the experiences of being in different rotations, providing patient care and finding value in their status as medical students. One student described providing patient care and feeling engaged on the obstetrics and gynecology rotation:

I found personally as a clerk if you were engaged that you could really help the flow of patients on that rotation. And as a clerk, once you’ve done enough checks and done enough exams, you are given the autonomy to go in there and do an exam, write up your history and physical. You can get a nurse to help you go do a cervical check or you can get a resident to help you do a cervical check. But you are given the autonomy to go and see the patient. You don’t have to ask to go and do it. So that I really felt like I was engaged because I would help. (Student Participant #6)

Being able to help patients through working with the team greatly contributes to students’ “feeling like a doctor” by doing things that practising doctors do; this helps them gradually build a professional image and construct a professional identity for themselves. One student emphasized the value of seeing patients in emergency rotation and how it contributed to identity formation:

Emergency was really cool...you’d go in and see a patient...take their history and you’d do your physical exam to figure out what they might have... After that you’re like I have a few ideas in my head of what this might be so you order your tests and your imaging and because we’re allowed to write our own order in Regina so we’d just quickly review with our preceptor and then they would be like maybe don’t do this one yet or maybe add this thing but we would really be doing all of that stuff. And we would be following up on it and you are doing all of the steps that we learn about in lectures and then you’re really thinking about it yourself...That’s kind of one of the cool things to really feel like a doctor is emergency. (Student Participant #13)

Despite doing what doctors do and “feeling like the doctor”, students also recognize that there is enough double-checking in clerkship to make sure they are providing safe patient care.
According to student participant (#10): “Well, you’re still concerned about making mistakes. But there’s enough redundancy in place that you can kind of take risks and start to learn how to be a doctor without having to worry about compromising patient care.”

Some students acknowledged that the encounter with patients could sometimes bring stress and discomfort. Students sometimes evaluate their own performance from the patient’s perspective. According to one student:

If I see a patient and don’t know anything about the condition, never heard of it, don’t recognize any of the medications and I’m awkward and shy, and the patient feels really uncomfortable; I think in their head they’ll think they’re receiving worse care. But in reality, there’s a resident above me that would know everything and be able to make good decisions. And there’s a physician surveying that. In reality the care that they’re receiving isn’t impacted by that at all. But I certainly think the fact that I’m aware that patients believe that the care is dependent on how the medical student is going about things, makes me very much more on edge and more serious about how I go about it. (Student Participant #16)

The conversations with patients can function as feedback to what students should improve on with respect to knowledge and skills. Not being able to answer the patients’ questions could bring discomfort to students. It could also motivate them to fill knowledge and skill gaps, which is a self-motivation to improve from “being a doctor” to “being a good doctor”. Through patient encounters, students also start to put patients at the centre of their learning and identify a broad range of qualities that make a good doctor. Below is one example to illustrate how students realize the value of communication and their improvement on that skill because of the practice of “talking to people” in clerkship:

[In clerkship] I spend way more time talking to patients and interacting with people than the studying, or the comprehending, or the learning, or being taught. And certainly my psychiatry rotation has gotten me to be way better at talking to people, way better at getting people to talk. Or talking to people about sensitive issues. Or being able to direct patients a certain way to answer certain information maybe more efficiently, effectively. Or getting them to open up...just because every day all day is spent talking to people. One could really see how someone who’s skilled in communication could really begin to excel. It’s really those that communicate effectively that are gonna do probably the greatest; have the greatest impact on their patient’s health, their patient’s understanding of their illness. (Student Participant #16)

Medical students’ encounter with patients is crucial for their understanding of professionalism and PIF. In clerkship, students actively provide patient care, assume the role of physicians, and are seen by patients as members of the care team. The patients that students encounter in hospital and clinic allow them to see the real examples that they only hear about in lectures in pre-clerkship and shift their attention from learning the knowledge to applying the knowledge. Patients also have a profound impact on students’ understanding of the work that physicians do to provide good patient care and the role that they play in society. Lessons on professionalism
that students learn from clerkship and especially, patient encounter, will be discussed later in 6.3.2.

6.3.3 Fitting into the environment

Clerkship represents a new environment, with different expectations and requirements from that of pre-clerkship. In clerkship, medical students learn within the community of medical practice and are fully immersed in the environment with its various stakeholders, including patients, preceptors, and other health care professionals. They not only try to apply the knowledge and skills learned through pre-clerkship but also manage interpersonal relationships. Within the community of medical practice, there are also smaller communities of different specialties in medicine. As the group that has the least knowledge and experience, medical students also learn within the hierarchy of medicine. Students’ learning experiences are recursively organized by the structure of clerkship and the learning environments in different rotations. They constantly acquire new knowledge of the contexts and conditions of their learning and utilize such knowledge to coordinate their actions. This section describes how students fit into the environment by adjusting to different expectations in medical specialties and gradually taking on more responsibilities.

6.3.3.1 Learning in different specialties – adjusting and coping

Clerkship, as it is currently structured, provides students with mini glimpses of different areas of medicine. Although there is the general understanding of the culture of medicine, it is also recognized that different specialties have their unique practices and contribute to a distinct professional identity. For example, a primary care physician’s professional identity would be quite different from that of a specialty physician. How students fit into those different cultures and how they resonate with them influences which specialty they choose for their residency and future career. Choosing a specialty is an important milestone in students’ professional identity formation. One student reflected on the importance of learning the culture of different specialties in clerkship:

I find it very important to learn the culture. Some of the culture I don’t want to associate with at all, or I don’t agree with, or I don’t learn best in. And so I would not be interested in working in that field in the future, but to be able to experience it and recognize it as a different culture from other areas I think is really important, and definitely helps one to recognize what they want in their future working environment or specialty. (Student Participant #16)

Students’ interest in medicine could potentially change from when they start medical school, to pre-clerkship, and then clerkship. Students might have an idea of what they want to pursue at the beginning of medical school, and start to have more knowledge and learn more materials of different specialties through pre-clerkship. Finally, during clerkship, through living and seeing the day-to-day, students observe the routines of each field and start to evaluate their options.
Students seek strategies to adjust and cope with the pace of learning in clerkship and its frequent transitions to new clinical settings. One student described the discomfort and learning to fit in:

I think the biggest stress in med school, and it’s a good stress, is the constant learning curve. And in clerkship, your constant learning curve is every six weeks. You go from pediatrics and you just start to feel a little bit comfortable and then you go to gen sur. You just start to feel a little bit comfortable, and then you move to another rotation. So it’s just kind of a rollercoaster. But I think you learn a lot by trying to…fit into that environment. (Student Participant #6)

Students go through the day-to-day at a heightened level of discomfort and become more comfortable with adapting to different practising styles and different personalities because of the rapid turn-over in terms of learning environments. Students also project an image of confidence and take pride in the aspects of knowledge that they do know or are aware of to manage the discomfort.

Besides the knowledge- and skill-applications, managing interpersonal relationships is another prominent part of demonstrating professionalism and learning the traits of an appropriate professional identity. Students commented that fitting into the environment was one of their priorities in clerkship. This expectation is not explicitly stated but received through interactions with others. Managing interpersonal relationships is especially crucial when evaluation is concerned. In the following example, one student discussed the importance of “being a nice person” in clerkship:

I think there’s a lot more than being a nice person at the beginning but in the end that’s kind of things that if you don’t do those things you are going to get a bad evaluation no matter how much you know, for sure. Because people mark you on how much they like to work with you so… Yeah, I think it is easier for the extroverts. (Student Participant #13)

Personality and who the students are before medicine could in a way impact how fast and well they adjust to the expectations and fit into the environment. Students quickly understand the expectations, learn the rules, and perform as told either explicitly or implicitly. There are students who take responsibilities to the next level, volunteer for more tasks, and try to go overboard to impress preceptors. There are also students who lay their heads low to avoid making or creating a problem. According to one student:

I try to fit in insofar as I’m not standing out like a sore thumb. I don’t wanna be the gold star on the team, I just don’t want to be the person that’s obviously out of place or who doesn’t really fit into the culture of that particular service, right? Cause every service a little bit of a different personality, a little bit of a different interaction with other people. I just try to morph into whatever the expectation and the trends are there. And kind of just fly under the radar as long as I can. (Student Participant #14)

Clerkship can be a challenging phase for students who do not naturally have or whose personality is in conflict with the expected qualities of an appropriate professional identity. When there is not enough support or mentorship in place, students can feel like they are giving up a part of themselves in order to fit into the environment and be accepted as a member of the community.
6.3.3.2 Learning within the hierarchy – graduated responsibility

The variation of expectations in different specialties is also exemplified in the role medical students play in providing patient care. As learners, clerkship students play different roles and have different levels of responsibilities depending on the different rotations they are on and different attendings that they work with. This can be observed in the following example:

Like family medicine, I’ve always felt I play more of an active role, and input and stuff like that matters. And I’ll see patients and do a lot of the ground work on my own. And then an example with Pediatrics, if I saw a patient and it comes to the end of a shift, I’ll be involved in handing over that patient and discussing their pertinent information and what to watch out for, to the next on-coming team of residents. Whereas in other rotations like Obstetrics, I played zero role in hand-over. Even if it was a patient I saw, it likely won’t be up to me to pass on the information. (Student Participant #16)

Students believe the role they play in clerkship is directly relevant to the learning that comes out of clerkship. Being involved as a team member and providing input instead of just observing and asking questions provides the opportunities for medical students to think independently and apply the knowledge independently.

In clerkship, medical students start to see how the hierarchy of medicine (from clerkship students, to junior residents, senior residents, and eventually attendings) is manifested in providing patient care. The structure exists to let everyone experience the gradual responsibility to the maximum potential that they can safely and it is the expectations that medical students follow the order of communication in their work. Students feel the presence of hierarchy the strongest in rotations of surgery and internal medicine. According to one student that described her experiences working in internal medicine:

...internal medicine especially...the clerkship students were to talk to the junior resident which is first or second year resident...to talk to them first if you have any questions and you are not supposed to bother the senior resident which is third year unless the second year resident doesn’t know what to do. And then they’re the ones that talk to the attendings... There were a couple of times where I had a question and I know the senior resident has the answer to this but I don’t think the junior resident does so then I’d just go talk to the senior resident and a couple times the senior resident was just like, ‘Well, why didn’t you ask the junior resident first,’ There is this hierarchy that you apparently have to follow. (Student Participant #13)

It is not clearly stated to students that following the order of communication is the expectation and students might not know this before clerkship. However, through interactions with others (e.g., the senior resident asks the student to ask the junior resident first), students learn the rule and learn to follow the rule. These expectations also help frame and maintain the structure of medical school. The structure exists for a reason; however, by members in the structure rigorously following the order of the structure, it does not offer much flexibility to students’ learning in certain situations.
Besides the variation in rotations, students’ learning experiences in clerkship could also be dependent on the preceptors they work with, especially whether the preceptors are dedicated to teaching clerkship students and providing mentorship. In the following example, one student reflected on medical students’ responsibilities and their daily routines on the ward and expressed the wish for more independence with writing orders:

Well typically on most rotations you go to work in the morning. You run your rounds for your patients and then you’re assigned responsibilities. Then student goes and sees the patients by themselves, has a clinical interaction, comes up with a plan of what we should do moving forward, presents it to their resident, and oftentimes that plan gets approved or denied... It’d be nice if we were able to write a few more orders than we do because I think we would get more clinical experience that way...it would just be nice if we could do things like ibuprofen, Tylenol, simple investigations like ECGs and chest X-rays, things where it’s very low risk. Consulting other services or consulting therapies. (Student Participant #10)

The less that students can do independently, the less of a sense of responsibility they have for their patients and the less inclined they are to go that extra step to provide recommendations and manage patient care. There are different approaches that preceptors who are dedicated to teaching could use to elevate students’ learning experiences and outcomes. Besides the individual work with patients and preceptors, another crucial learning opportunity for students in clerkship is doing rounds with preceptors. One faculty specifically described how she would try to involve students in rounds:

I try and involve them in rounds so that they’re writing orders, or if they’re not presenting on their own patient, that they’re writing orders for someone else. I find that’s one way that can help them stay engaged in a conversation cause if they know they have to write the orders then they’re following the conversation to know what to write, and it keeps their learning kind of active that way. So I tend to rotate those tasks on rounds, so one would be presenting, one might be looking things up on the computer, like lab results or x-rays, and one would be writing the orders. Medical students in evaluations have told me that they appreciate being a part of the rounds and engaged in the rounds, rather than just being in an observer role. (Faculty Participant #10)

This faculty member clearly has interest in teaching medical students and takes into consideration students’ feedback to create opportunities for active learning. Through completing the segmented small tasks, medical students get more familiar with and start to piece together the different responsibilities of physicians.

The two learning mechanisms discussed in this section are particularly relevant to students’ professional identity. Medical students adjust to expectations by giving up some “not supposed to do” and picking up some “supposed to do” and manage interpersonal relationships in order to fit into the environment. Students might not explicitly articulate the rules and expectations or be in a situation that requires them to explain their behaviours; however, they become knowledgeable in how to be clerkship students. Students have a better idea of their current roles as medical students and future roles as physicians, and a clearer picture of where they fit within
the community of medical practice through learning in different specialties and learning within the medical hierarchy.

### 6.3.4 Self-directed learning and feedback

Compared to mostly classroom learning in pre-clerkship, clerkship requires a lot of self-directed learning. In order to pass clerkship rotations, students still need to meet multiple objectives in different areas. However, there are fewer written assignments and exams. Even though some rotations can be very work-intensive for students, there is still some flexibility where they can individually seek learning opportunities. Medical students are generally motivated to explore these opportunities. One student described how that was possible in clerkship:

So often on neurology, I’d only be given two or three patients. You go and see them and then you’d have nothing to do for the day. And often I was like, ‘Are you sure there’s nothing else I can do?’ And same with general surgery, what I did for that one was pretty much just attached myself to one of the residents. Because they always are busy. Like they’re always running around doing stuff, whether or not they’re seeing a consult or not; there’s always work to be done up on the wards or checking on imaging, checking on lab work. So I would just pretty much be their shadow and just move with them. (Student Participant #6)

Another student talked about the value of “taking extra steps” and setting his own objectives for clerkship learning:

I know that I am certainly more confident going into residency now, having done clerkship. It’s hard for me to tell if passing the required components of those rotations is what makes me more prepared or my own efforts in addition to those things. Going into those core rotations, I had my own objectives of what I wanted to get out of it, on top of everything else. And I wonder if I had just done the bare minimum, would I still feel confident going into residency. (Student Participant #15)

Even though students use self-directed learning to improve on their knowledge and skills, a significant component of self-directed learning in clerkship is on the non-clinical aspect of medicine. It often involves learning to approach a situation when there is no correct answer or guideline. Students identified trial and error, together with reflection, as a key aspect of self-directed learning. One student reflected on this with a learning experience in primary care:

For primary care...the chief complaint says headache, but you’re not expecting to see somebody with HIV encephalopathy that has a long history of distrust with the medical system and doesn’t really want to see you but is there because they want their headache treated. And so you go into a situation like that and a lot of it is trial and error. You figure out what’s going on as you’re in there, try and establish rapport. Maybe you fail, maybe you do well. You come out of the clinical encounter and talk about it with your preceptor. They provide you with some suggestions. But I think the most important learning comes from when you go home and reflect on your clinical experience that day and think about
what you could have done better, what you maybe would try next time. It was maybe more retroactive learning where you learn by reflecting. (Student Participant #10)

Patient interaction and students’ observation of clinical practice can be intensive during clerkship and the lack of opportunities to debrief can make students feel they are holding things. In the following example, one student shared a learning experience in anesthesia rotation in clerkship:

I had a day in a pediatric OR with a surgeon who performs surgical circumcisions on boys. There were three boys lined up to come in, that happened to all be brothers. They were a refugee family who had recently immigrated to Canada. They all had the same diagnosis that gets the procedure – surgical procedure – covered by our health care system but they didn’t have that condition. But the surgeon, in the paperwork, documented that they had that so it could be surgically performed and covered, so they wouldn’t have to pay for it... First of all, it could be dangerous, these boys are under general anesthesia, there’re risks that come with this, and it’s not even medically indicated. Also, we’re lying on the document. The surgeon lied on the documentation because the surgeon wants to get it covered for this family. So we’re abusing the system by falsely writing something on a record, and taking taxpayers’ money to pay for it. But the third part, like you asked, do you feel comfortable talking about it with your preceptors? Well I brought it up. I talked to the surgeon, who said, ‘But you know if I don’t take these patients on and perform this, then they go to a community clinic...it’s maybe not as safe, there’s higher risk of complications... I don’t necessarily agree with it, but it’s the less of two evils. I would rather make sure if it’s gonna happen, it gets done right, and that there’s no unnecessary complications for these children.’ (Student Participant #15)

In reflecting on this experience, the student discussed how it impacted his understanding of the role of physicians and his PIF:

...for me that was so mind blowing, because if you’re talking about professional identity formation and having an internal crisis about it, it totally challenged what I thought my job was going to be. I thought about disease presenting itself and finding the best approach to a disease. Now I have a cultural issue that has medical consequences and trying to choose the least harmful path. That is not something that we talk about in school, at all. I was fortunate enough to feel comfortable to challenge it and have that conversation; I don’t think a lot of students are. (Student Participant #15)

The above reflections demonstrate a deficiency in the CoM’s teaching efforts because students are left alone to explore these crucial topics and issues. Dilemmas like the one identified in this example will continue to challenge the medical profession and cannot be easily solved. However, avoiding these issues instead of starting the conversations does not support learning. Currently the real-life encounters in clinical settings are not utilized to the full advantage to support students to perform the non-medical expert physician roles and teaching on these competencies are not embedded in clerkship.

Student participants emphasized the importance of self-reflection in clerkship but also identified the need for more opportunities to reflect with preceptors. Clerkship provides real scenarios and
students call for more opportunities to engage in conversations about professionalism and physician roles with mentorship. Students believe that there should be time and space to debrief about patients with either attendings or residents who are involved in their care. The journey from medical training to medical practice is a continuum. The challenges that medical students observe in clerkship are not unique but rather universal problems that practicing physicians also must work through. Conversations and reflection on the grey areas of practicing medicine have to be facilitated by an encouraging and supportive environment where not only students but also faculty can share their vulnerability, uncertainty, and confusion freely without the fear that they are going to be labelled unprofessional.

The above two examples have demonstrated that students’ self-reflection in clerkship is closely related to faculty providing feedback and mentorship. Feedback is a very important factor that contributes to learning but is often identified as missing or not sufficient in clerkship, especially the informal feedback. With the changes that the CoM has made over the past few years, formal feedback is offered more frequently but often comes in the form of checked-box evaluation:

> I think there’s certainly some pressures just with the way that assessment goes with the evaluations and the checked boxes. They keep more tabs on us nowadays... Before there wouldn’t be a formal way of assessing every visit, whereas it seems to be now within our curriculum at least...there’s formal assessments a lot of the time. When you are with a doctor in clinic, there’s an assessment. (Student Participant #16)

Informal feedback, often in the form of mentorship, is, according to students, more useful to their learning. In the following example, one student reflected on the lack of feedback that is based on direct observation:

> We’re in groups of four usually for our clinical rotations. And depending on your preceptor they’ll just like, ‘Here’s a patient. Go see them and come back to me.’ Or you’ll go in pairs... It’s good to get experience clearly by yourself with the patient and interacting with them. But then you don’t get any sort of feedback if they haven’t observed you at all. So I think an important part to being able to learn would be being observed in the early stages. (Student Participant #2)

Preceptors can only provide feedback based on the notes that students take because of the lack of direct observation. Some of the important elements of patient encounter are not observed and students cannot receive feedback on them. This is left to students to be self-motivated to ask preceptors for constructive criticism and feedback. The limitations on preceptors’ time to balance providing patient care and education is identified by faculty as the biggest reason that direct observation of learners is not happening as often as it should be.

Self-directed learning is a very unique feature of clerkship, which provides students the flexibility to explore the different dimensions of medical professionalism and physician roles. Some students take advantage of this flexibility and look for ways to engage preceptors for feedback and to explore the dilemmas that continue to challenge the medical profession, which show medical students’ agency in learning. However, a better and more supportive learning environment requires more than the self-motivation on students’ part or dedication to teaching
on preceptors’ part. The system in which students are trained in clerkship needs to recognize the training of learners as one of the priorities and have mechanisms built in for preceptors to offer feedback and mentorship. Time and resources need to be invested so that preceptors and learners could collaborate to produce better learning outcomes and provide better patient care. This is essentially a key feature of the community of practice in that people not only transmit knowledge but also co-produce knowledge. The next section revisits the three different types of curricula and describes the impact of curriculum gap.

6.3.5 Curriculum gap

The discussion in the preceding four sections concerning students’ reflections on their clerkship learning experiences has already illustrated that there is a curriculum gap on professionalism and physician roles in medical education that has a counterproductive influence on students’ learning. This section integrates both students’ and faculty’s concerns on the impact of this curriculum gap. The ideals and guidelines on professionalism and physician roles are presented in pre-clerkship and best practices are preached; however, students often encounter difficult and challenging situations that present questions that are grey instead of black and white. They also find themselves in situations that do not reflect or are in direct contrast to the ideals and guidelines presented and preached and left alone to “navigate the storm” without mentorship or constructive feedback.

Faculty participants recognize that, besides the formal curriculum in clerkship, there is a great deal of informal curriculum and hidden curriculum happening simultaneously. In reflecting on the contrast between the formal curriculum and the hidden curriculum and the strong impact on students’ understanding of professionalism and PIF, one faculty member commented:

I think probably one of the biggest challenges we still face is the hidden curriculum. So we give lots of guidance around professional behaviour, what it is to be professional, all that kind of stuff. But then they see things when they’re shadowing or then when they go into their clinical rotations, they encounter things that are not consistent with that. And what kind of influence does that have on them? It’s pretty strong. And especially if they see it over and over again. (Faculty Participant #3)

The faculty concern was confirmed by students’ reflections. The following example from one student reveals the impact of real-life observations:

A physician that we ended up working with...was not culturally sensitive. And was also exposing the patients to unneeded physical exposure as well as making them feel uncomfortable. We got a sense that it was not very patient-centred. There was just a bit of a disconnect with cultural sensitivity... I feel like the hidden curriculum aspects just stand out so much more for me, in that they’ve made more of a lasting impact. So I think that it might be my own bias but it’s hard to speak to what I learned in the lecture when it’s just overpowered by what I’ve learned in a deeper meaning in real life. (Student Participant #5)
The contrast between the professional and idealized image of physicians portrayed in pre-clerkship and students’ observation in clerkship creates a curriculum gap and contributes to cynicism among students. One student commented on the gap between what they are taught in pre-clerkship on maintaining professionalism with pharmaceutical companies and representatives, and what they observe when they are on the wards or in clinics in clerkship:

We receive content that shows here are the boundaries with pharmaceutical gifts. They provide the same narrative of physicians and professionals. They’re in their own little box of perfect behaviours, and that we need to be like that... And then we get into practice and we see that, wait a minute, the pharmaceutical companies are giving gifts to everybody all the time; and people are accepting them. So there’s that disconnect. (Student Participant #15)

Both students and faculty argue that medical school cannot prepare students with the right answers for every scenario. Medical school could try very hard to envision every possible scenario with pharmaceutical gifts but something will happen that falls outside of those criteria and it is up to students to make a critical decision based on the new information. The old model of influencing behaviour does not recognize the complexities of practice or students’ abilities to undertake critical thinking.

Instead, a more appropriate approach is to continue to engage them in professional conversations when they face a gray situation so students can hear different perspectives and feel comfortable and supported to navigate the scenarios that challenge their understanding of professionalism and physician roles. In this way, medical schools could help students build competency in approaching the ambiguity of medicine and medical practice, especially when they put the hope on the incoming physicians to change the professional culture.

Faculty reflected on their concerns about structural factors in medical education that are beyond individuals’ control and contribute to the gaps between the intended and unintended messages on professionalism and physician roles. One identified factor is the extensive demands of service and learning in clerkship, which can lead to students losing the bigger picture of patient care and physician roles. According to one faculty:

I think we see a lot of students come in with the broad perspective about health and wellness, an urgency to understand why things are this way, a lot of passion and energy... And I think what happens is the demands, the busyness of trying to learn and provide a service...takes up so much time and energy...when they’re really busy developing tunnel vision that is more about survival, performing in the phase that they’re at whether it’s in a clinic or hospital or O.R., eating and sleeping and maintain basic relationships. And the perspective and vision of the bigger issues that ultimately affect what they’re doing in our health care system lose importance strictly because there’s so little time. So that’s a bit of a struggle to maintain a professional identity that is a little bit more in the spirit of social justice and health equity. (Faculty Participant #5)

The tunnel vision of surviving and completing the immediate task (whether it is an exam or seeing a patient) is not unique to clerkship. Throughout the four years of medical school, there are
always different goals that compete for students’ time and energy. Within this context, most students will choose to prioritize learning how to treat a given disease over how to perform the other physician roles better despite that the physician roles other than that of the medical expert are emphasized in documents and preached in classrooms as equally important. Students choose the priority from the tacit knowledge reflected in how they are evaluated and their observation of how medicine is practiced in real clinical settings.

Medical school has the power to shape how students turn out after four years of training through organizing the curriculum and including/excluding or emphasizing/neglecting certain aspects of knowledge in medicine. The Five-Year Strategic Plan (2017-2022) released by the College states that: “We are leaders in improving the health and well-being of the people of Saskatchewan and the world.” The Mission, identified by the College on its website, is:

As a socially accountable organization, we improve health through innovative and interdisciplinary research and education, leadership, community engagement, and the development of culturally competent, skilled clinicians and scientists. Collaborative and mutually beneficial partnerships with Indigenous peoples and communities are central to our mission.

Several faculty participants reflected on the document and commented that simply listing these priorities in the mission document is not sufficient for medical students to internalize them as their responsibilities. Drawing upon the health disparity among Indigenous and non-Indigenous populations, one faculty member commented on the gap between physicians that medical school is producing and society needs:

As a medical school, we talk about social accountability and the importance of that... We can look at the changing demographics and know that our Indigenous population is increasing as a percentage of our overall population and our health care providers – all of them including physicians – need to have the right skillset and the right approach to provide care in a way that’s respectful and not colonial and not oblivious or unconscious to the effect of transgenerational trauma. And I don’t think we talk about those things enough at all. So what happens is people graduate, and they might go to places in the province that they’re needed but they don’t necessarily have the skillset for optimally working in a professional manner with the populations that we need to serve. Or they choose specialties, that to be quite honest, our society doesn’t need. So what’s the disconnect from the time we admit them to the time they leave. Why do they tend to go to the specialties that pay high income and not to the specialties where there’s the greatest need? The greatest need is family medicine and psychiatry. But we had two positions in La Ronge that didn’t get filled this year. Why is that? So to me part of it is the students have this idea that they can be whatever they want to be in medicine and they’re not connecting to that mission of social accountability. I don’t think this is unique to Saskatchewan. I think this is a problem across the country. (Faculty Participant #9)

Even though social accountability and a commitment to Indigenous health are listed in the mission document, the informal curriculum does not support the formal curriculum, resulting in the formal statements having mostly symbolic functions and students not connecting to these
values. This faculty member further reflected on how the hidden curriculum in medical school is actively discouraging medical students from pursuing careers as family physicians, especially early on in their training:

The hidden curriculum for family medicine is that family doctors don’t know as much as specialists. The default mode which is the mode we use here is that a lot of the teachers that are brought into teaching who teach one part of the curriculum are specialists in the Health Sciences Center, closely affiliated with the medical school and not from the community and not from primary care. So the medical students early on don’t get exposure to family physicians who can teach them. So the hidden curriculum message is that the only people that have the expertise, the valuable knowledge to pass on are people who are specialized in those fields. When in actuality I think at that stage in training, it’s generalists that they need to be exposed to. (Faculty Participant #9)

This negative impact was indeed reflected in students’ comments about their limited understanding of family medicine as a specialty in pre-clerkship. They later had changed perception of and respect for family physicians when they experienced the specialty through rotations in clerkship. This will be discussed later in the section of “changes in perception”.

There are many ideals that the CoM is emphasizing in the formal curriculum in conjunction with the directions the health care system is moving towards, especially interprofessional practice and patient-centred care. Students recognized that these practices are happening to a certain extent in varied forms but also identified some gaps in what they are taught in the classroom and what they observe in practice. On interprofessional collaboration, one student reflected:

So we are taught a lot on interprofessional ideas and we do some projects interprofessionally with other Health Science students. But as far as what we’ve been able to see on wards, I think there’s still a lot of isolationism in the medical profession. When we go into the hospital...we’re almost taught that way too. All we really see is the one physician that we’re supposed to be taught by that day or for that session...it can be hard to see if there’s much interprofessional relations that they rely on. So if you don’t have a model for things, it’s hard to learn it or do it for ourselves. (Student Participant #4)

The mechanisms to facilitate interprofessional practice are not well embedded in the health care system to demonstrate to students its importance and benefits or provide opportunities for students to practice the required competencies.

The same argument could be made about the objective of providing patient-centred care. In the following example, one faculty described the forces of the hidden curriculum in clerkship:

It’s hard to know what they observe in clinical environment. There’s always a gap between what we as clinicians intend or hope to do and what we actually do. And there’s multiple stressors and lots of information coming in, some of which we might not interpret correctly or we might miss. And we may miss the mark on provision of patient/family centred care. We also work in a system that doesn’t always support it because of policy and system level things. And then of course we’re limited by our own interpersonal skills as well, and our insight as to what we need to develop and how we can build our strengths
as a physician to improve that. I think we don’t always practice what we preach. (Faculty Participant #10)

Despite the emphasis through the formal curriculum in pre-clerkship, students’ observations in clerkship can easily contradict and overshadow the ideals preached. Students might not be able to see how these ideals are achieved in real scenarios or have the opportunities to practice their skills on these topics. Therefore, a lot of the learning of patient- and family-centred care and interprofessional practice is seen as optional and depends on “students’ interest” of whether they would like to further pursue these goals of medicine.

With higher expectations from patients and the society, the upcoming physicians currently in training might face the pressure to “do it all” despite the formal curriculum advocating for a better work-life balance for physicians and medical students. One student explained why systemic support is needed for transitioning to a better work-life balance and interprofessional collaboration:

We’re shifting from a culture of medicine that was very work-focused and paternalistic towards a culture of wellness, recognizing that all health care workers have to be well to be able to provide for their patients. And moving into a more collaborative health care team approach. But I think maybe because we’re still transitioning, we’ve got the values of both happening right now, where you not only have to work a lot and well and professionally and flawlessly all the time, you also have to be well and make sure that you’re taking care of yourself. So it sort of ends up being just another thing on top of. It needs to be recognized that health care workers can’t focus on those values until the structure around them also does. (Student Participant #4)

The structure, system, and context need to support physicians to achieve the values that the health care service is aiming for. The expectations are not unreasonable; however, individuals need to be supported in order to make happen the changes, which benefit not only the students but also patients.

The curriculum gap on several areas identified in this section illustrates the need for the informal curriculum to align with the formal curriculum to support students’ learning. The alignment of the content delivered in classroom settings in pre-clerkship and students’ observation in clerkship is especially important. Medical education, especially clerkship, is not a straightforward path of instructors delivering and students receiving/applying knowledge. It is, instead, a social practice and a process of socialization, which require students to have their own engagement with the knowledge that is delivered. Mixed, and especially contradictory, messages could significantly undermine the good intent of the formal curriculum and students’ motivation to learn.

Clerkship is situated learning and the learning of applied knowledge. What students observe preceptors do tend to have a much bigger impact on their understanding and future behaviours than what is preached by preceptors. Medical students need consistent messages and guidance, which depend on evaluating the learning mechanisms that make an impact on their learning experiences in clerkship. These include role modelling, patient encounter, fitting into the environment, and self-directed learning and feedback. Following a detailed explanation of these
learning mechanisms, oriented to answer the research question of how medical students learn professionalism and develop professional identities, the next two sections describe the learning outcomes. Section 6.3 discusses participants’ understandings of professionalism and physician roles, while 6.4 presents data on the importance of professional identity and formation of professional identity.

6.4 Understanding of medical professionalism and physician roles

When asked to describe their understanding of the medical professionalism, many participants went beyond the concept of professionalism and reflected on their understanding of the medical profession on a broader scope. The very idea of understanding of professionalism is deeply rooted in the understanding of the profession of medicine and what qualities make a good physician. Participants’ discussion of professionalism and physician roles tends to focus on relationship-based professionalism instead of individual conducts and is more patient-driven instead of profession-driven. However, the function that the medical profession collectively serves in society, the socially constructed nature of professionalism, or the impact of other stakeholders on the understanding of medical professionalism is much less discussed. While the first sub-section describes participants’ general reflections on professionalism and physician roles, the second sub-section specifically discusses some of students’ changed understanding through medical training.

6.4.1 An understanding of the medical profession

The idea of being caring and helping people, to many participants, is still the fundamental aspect of being a medical professional. This is especially emphasized by students who recently got into medical school and finished the admission process during which they had to demonstrate that they are caring people and would be a good fit for medicine. One student discussed the motivation for studying medicine:

I really enjoy working with underserviced population, whether that is internationally or Northern Saskatchewan or Northern Canada. I thought medicine would be a good way to be able to help in situations like that in a way that not everyone else could... I wanted to do family medicine and be their first contact in the health care system and get them where they need to go and address some of the things that are not necessarily medicine related but social related that affect people’s health. I know it sounds cheesy to say I want to help people but I guess that’s really what it is. (Student Participant #13)

The altruistic aspect of putting patients first is still very present in medicine. Although there is better recognition of physicians’ and medical trainees’ wellness, the nature of the work of medicine makes it continue to be a very demanding profession. As one faculty explained:

Certainly physicians at my stage of life and newer physicians coming in expect that they’ll work reasonable hours. But the basic fact remains that you can’t leave at the end of the day with unfinished patient business that will affect that patient’s wellbeing. So you must either hand it over to the next person or you must complete it yourself. So that hasn’t
changed. There still is the expectation that in the parameters of when you’re working, the patient’s interest has to come first. (Faculty Participant #7)

Being humble is a unique quality that participants consider important for the medical profession that has traditionally carried and still carries a very high status in society. In remaining humble, physicians can recognize the responsibilities that come with the privileges to maintain a supportive relationship with patients and collaborate with other healthcare professionals. Below is one representative quote from a student:

...part of it is you are an empathetic person and someone with an issue that is life-threatening and has a tremendous impact on their life, knows they can come to you, I think for me that’s the key part of what I want to craft. I want to be a professional who, no one ever feel intimidated or unsure about whether or not they should bring it up. I never want anyone to feel like they’re taking up too much time. (Student Participant #12)

A large percentage of participants’ understanding of the medical professionalism describes qualities that are deemed by some in medicine as the “soft skills”. The importance of these qualities is well summarized in the following example:

I think science or the knowledge of medicine is what will get you to that point, to being a doctor. But it’s going to be the humanity and the interaction with fellow human beings that’ll lead you to succeeding. (Student Participant #8)

Providing patient-centred care through listening to patients’ goals and concerns, understanding the whole spectrum of health and care, providing education to empower patients, and advocating for patients are some of the qualities identified by participants. One faculty member discussed professionalism as recognizing the role of patients and families on the health care team and putting them at the center when providing care:

...actually finding out what the patient wants and it’s unfortunately deemed as the ‘soft skills’, which personally drives me crazy because they’re actually very difficult skills to master... Not what is our medical goal for this person or what does this guideline says. It’s what that patient’s experience in health care is and how they want to be treated and if there are reasons to deviate from our standard, guideline-based care. Recognizing that the patients and their families have their agenda too and they have questions that they want to ask and need to be answered. (Faculty Participant #6)

The key element of professionalism often lies in the intangibles in medicine, which are often overlooked by medical students. In relating professionalism to the roles of physicians, one faculty commented:

Being a professional in medicine is not only about prescriptions. It’s not only about surgeries and hospitals. It’s about different interventions in the society that can help the patient in front of you and could have a higher impact. (Faculty Participant #2).

The above examples have demonstrated that the definition of professionalism is becoming less profession-driven and more patient-driven. Under the context of changing expectations, to
provide care that patients and society need, physicians and medical students need to have the knowledge and skills to perform the non-medical expert roles.

Similar to the last comment, some participants took it even further and argued that there are different ways that physicians could approach medicine and perform their roles in society to have bigger impact on the overall health of the population. They hold strong views towards the very nature of medicine, which is less talked about or can seem foreign to many who work in the medical field. In the following example, one faculty member discussed how his understanding of medicine influenced his medical practice:

I approach medicine from a social justice perspective. That was basically the whole reason for coming in. So medicine to me was a tool and a set of skills to move forward issues of human rights, access the health care injustices that we have. I very much feel that medicine more than anything is a social science. A lot of work experience reinforces that. We use scientific principles but we treat people in a social domain and our system and how it works and functions and who it provides to and who it doesn’t – those are all policy decisions. I think one thing that can come up in medicine is people saying, ‘I’m in a helping profession. I show up every day. I treat my patients well. I give them the best quality care possible’. And if I’m coming in and saying, ‘Well actually there’s more we could be doing’. If it’s not done skillfully it could be perceived as a criticism or an ask for them to do more, rather than what we would like to see is people taking this up and seeing ways in their practice where they can actually be more effective with their patients, stop some of the patterns they have for repeat visitors who have structural things in their way. And maybe being a part of resolving some of those structural issues. (Faculty Participant #5)

This more upstream approach of delivering health care services is having more presence at the CoM as exemplified by the clinical and non-clinical research projects and initiatives featured by the College on its website (College of Medicine, 2021). These include initiatives on Indigenous Health to improve access to care and patient outcomes, and students’ and researchers’ work in the community to promote health equity through advocacy, education, and collaboration. These practices, programs, and initiatives might, in the long term, contribute to a new aspect of medical professionalism that addresses inequality in access to health care and ultimately promote medicine’s social accountability.

Maintaining professional relationships with colleagues is also important in health care, especially in situation where there could be different priorities and different opinions on best approaches to care. Being able to resolve conflicts, which are deemed to happen in reality, in a professional way is also considered one aspect of the medical professionalism. This is well explained in the following example by one faculty, who distinguished between warranted and unwarranted conflict:

Warranted conflict would be a difference in opinion regarding a care decision – are we gonna work on oral feeding this week even it’s inadequate nutrition or are we gonna tube feed to optimize nutrition... And so a professional would be able to identity that the goals of the different team members are in conflict and then to sort out what’s gonna work best for everyone including the patient...so conflict management is really a big piece of
professionalism in medicine. Unwarranted conflict would be just getting caught up in the day-to-day human failings that we all have. When I think of a professional in medicine, I think of someone that can navigate all of that in a way that’s positive and resolves conflicts in a patient’s best interest, and still preserves the dignity of the individuals involved in a way that they can continue to work together and be a strong team. (Faculty Participant #10)

Managing professional relationships is rapidly becoming an important competency as interprofessional collaboration is being encouraged.

The aspects of building good relationship with patients, providing care and interventions that patients need, and understanding physician roles to collaborate with other health care providers are becoming central elements of the medical professionalism. As high as the expectations are, the nature of medical practice being social practice makes these qualities essential to providing optimal and efficient patient care. While the above reflections mostly come from faculty who have a more established understanding of their chosen profession, the next section discusses some of students’ changes in perception through medical school.

6.4.2 Changes in perception

In the interviews, many medical students commented on how their understanding of the medical profession changed through medical training, especially in clerkship when they were fully immersed in the community of medical practice. The learning, observation, and direct involvement in care contribute to those changes in understanding and perception. These experiences and students’ reflections on their experiences support them in gaining a robust understanding of professionalism and physician roles.

When reflecting on the changes in their perception of the medical profession, many students mentioned their changed perception of the different specialties in medicine. Students came to realize the diversity of medical practice through medical training. According to one student:

I wasn’t aware of how diverse everything was and how many different fields there were. And so coming into it, I kind of had this idea of what I wanted to go into. But now actually being here and being able to talk with different physicians and see all the different specialties, it’s more diverse and more complicated than I had thought. (Student Participant #3)

Many students particularly mentioned their changed views on family medicine as a specialty. In the following example, one student reflected on the decision to pursue family medicine:

From the start of medical school, I certainly did not know what a family doctor did, I thought they just looked in ears and listened to people’s hearts all day which is super boring. They definitely do not do that and I ended up wanting to do family medicine. One of the things I noticed is that patients really trust their family doctors often over their specialists which I did not realize before going into medicine. It shows how much building relationships with people over time really outweighs any amount of knowledge that you
could have because specialists know more about their specific subject. But I’ve had multiple patients that I have seen come into their family doctor’s office and they have gone to see a specialist and they have come back and they are like, ‘doctor, can you please explain what my specialist told me or can you please give me a second opinion, I don’t know if I believe them’. It’s obvious there’s a lot more to medicine than knowledge. (Student Participant #13)

Students also develop a deeper understanding of the way in which rapport with patients and interpersonal relationships impact patient care. One student discussed realizing managing people to be the most important part of what physicians do:

I think that coming into medicine I imagined a lot of it to be just learning information and then applying it to relevant clinical scenarios. But I feel like in real life, it’s more about managing people and their expectations. One thing I wasn’t really expecting was how time and the conversations that you have can factor into what your diagnosis and your treatment is going to be... Decisions that you have to make about patient care that have to do with your relationship with the patient is something that I wasn’t expecting to have to deal with. But yet we deal with them on a day-to-day basis and it’s probably the most important part of what we do. It’s about how to administer medicine so that it makes sense to them and makes sense for their life. (Student Participant #10)

Students also come to appreciate, through clerkship, the complexity and uncertainty that are often part of medical practice. One student commented on appreciating the slow aspect of medicine:

Being a doctor is not necessarily about saving people and prolonging life. It’s about preserving it and alleviating suffering. Because we watch a lot of medical TV shows where there’s a lot of quick fixes and people either live or they die. There’s no middle ground where people suffer. I think the suffering and the slow aspect of medical care is one thing that a lot of people don’t see until clerkship comes. And also what it means to watch a family member suffer. (Student Participant #11)

Another student described coming to accept the uncertainty in medicine:

I used to put medicine and doctors on a pedestal... When you make a diagnosis, you’re fairly confident. When I heard that doctors made wrong diagnoses, I used to be like, ‘What the heck is wrong with them?’ But it’s not that they’re incompetent. There’s likelihoods and you go with the most likely and it may or may not be the case. Not everyone presents the same way. So learning that medicine is more complicated in that sense is a good change. Knowing that not everyone’s going to get the right answer every time. (Student Participant #12)

The last part in the above example illustrates that gradually, with more understanding of the medical profession, students start to empathize and identify with physicians. They start to view the medical profession from physicians’ perspective instead of laypeople’s perspective, which contributes to them building a professional identity.
Through the different learning mechanisms in pre-clerkship, and especially clerkship, students get a more realistic understanding of medical practice and the roles of physicians and start to think and feel like a physician. The reflections by participants on the understanding of the medical profession illustrate that teaching around professionalism and physician roles is more than just what roles to follow or what is appropriate or not. There are many concrete but also intangible skills that make up the idea of professionalism in medicine and it is often the intangible qualities that make a physician stand out. The next section specifically addresses the concept of professional identity and dissects the process of PIF.

6.5 Professional identity

Forming a professional identity is more than just performing professionalism; it is a crucial process for medical professionals to appreciate their role in society, and in relation to patients and other health care professionals. Developing a specialty-defined professional identity that students resonate with based on their values and strengths is also an important step in medical education. Although there are common learning mechanisms that contributes to PIF, the very process can be very individualized based on students’ interest and life experiences before medical school. Students seek opportunities to develop an individualized professional identity, even as they study within a highly structured curriculum. In this section, I first present results on participants’ observations on the importance of professional identity in medical education and practice. I then move on to describe the process of medical students’ PIF, which includes further explanation of some of the previously identified learning mechanisms in clerkship, and some mechanisms that are less commonly addressed and not included in the previous discussion.

6.5.1 The importance of professional identity in medical education

Even though professionalism has a very consistent presence in everything that the CoM does, there is very little explicit mention of professional identity in the curriculum. Career advising and mentoring that includes understanding yourself and understanding different career paths is one of the exceptions and is part of the SinMS series. Professional identity is not listed as one of the vertical themes of the curriculum either. Regardless, participants discussed the importance of professional identity in medicine and medical education.

To internalize professionalism, students need to develop their own understanding within the broad and general principles and guidelines on professionalism provided within the curriculum. The same principle applies to professional identity in that students need to figure out what the framework of physician roles means for them and how they are going to undertake those responsibilities. Using the metaphor of “a dance”, one faculty member described the importance of developing a professional identity that students can resonate with:

Students aren’t actually going to be able to practice without some kind of professional identity and figuring out what their role is and what it is that they’re supposed to do in this little dance of seeing patients, working with other health care professionals and using their skills. So they have to resolve for themselves how they’re going to fit into that little
system. I guess ‘a dance’ is a good way of describing it because...it’s sort of a little back and forth that goes on and they have to know what it means to be a good doctor. (Faculty Participant #1)

Faculty tend to think that the development of a professional identity could help students maintain professional behaviours, as one faculty observed: “If students don’t have a clear sense of professional identity, they are more likely to behave unprofessionally – the safeguard might be low for them” (Faculty Participant #8). Students also echoed this motivational factor in their learning and practice. According to one student:

I think it’s important to have a sense of professional identity in that that can help lead the way that you conduct yourself with others. The professional identity can be something that motivates you to keep doing what you’re doing well, that sense of responsibility. And that motivation that drives you to care and to do good. I think that’s very important to maintain. (Student Participant #1)

Students also think that professional identity is important in that it can largely influence how they practice medicine and it would be very difficult to navigate the profession if they cannot identify with that identity. Professional identity has traditionally been valuable in medicine because of its many responsibilities, to patients and the public. However, it is becoming more important when health care is transitioning into an interprofessional model and collaboration is becoming a required competency. Medical students not only must understand their own physician roles but also need to appreciate the roles and expertise of other health care professionals. According to one student:

I think that knowing who you are and the role you play and how to engage with members of other fields is crucial to having a collaborated practice. You can’t really do this job on your own. You need to be able to be confident in your role and know what’s accepted and expected of you as a doctor and know how to treat different people based on their professional identities and how to interact with them. (Student Participant #14)

Professional identity can be adopted as an angle, through which students can come to grasp the work of other health care professionals and learn the mechanisms and best approaches for collaboration. The same approach could be used to support the transition of health care to patient-centred care. In the following example, one student discussed how the understanding of physician roles and professional identity could influence how physicians approach patients:

...the way that your role relates to the patient as we’re moving into more of a patient-centred care practice. Having that sense of professional identity is important to consider with patient in ways that allow them to have their perspectives heard and their needs heard. (Student Participant #1)

Professional identity is closely related to students’ chosen specialty, which means there are distinct professional identities within the profession of medicine. Based on the knowledge and experiences that students gain throughout their medical training, they choose the specialty that
fits their interests and strengths. According to one student who had just completed the residency match when interviewed:

I think each discipline has a professional identity. I’m thinking of one of my colleagues who matched to neurology. And she’s very cerebral, likes to think about things, the connectedness of things, loves research. That makes sense that she’s going there. Then I have another friend that matched to psychiatry. And that makes sense. She fits that identity of a psychiatrist. And then I look at myself and I’d say I’m very hardworking. I don’t like to stop. I like the craziness and that’s why I’m working in obstetrics and gynecology. My neurology colleague wouldn’t do well with that and I don’t do well in neurology... Each discipline has its own characteristics. (Student Participant #6)

Once students go into rotations in clerkship, variation in expectations start to emerge, which are carefully examined by students to find the right fit for themselves. One student commented that a professional identity based on interest is needed for career sustainability:

I think that your professional identity is rolled up into what your interests are. And if you want to enjoy your career, enjoy the work that you do, you need to build an identity for yourself in the way that you want to build your identity. And then you can enjoy a long career of what you’re actually interested in. (Student Participant #5)

Physicians share some similarities in their knowledge, skills, and attitudes, and the one singular identity, which medical students all aim to identify with. However, they still need to find out where they fit within the diverse world of medical practice and have a specific role they feel comfortable filling. While the importance of professional identity in medical education is established, the next section describes the process of students’ PIF, especially those contributors that are not covered in the section of learning mechanisms in clerkship.

6.5.2 PIF

The formation of professional identity, to many, is an ongoing process from the time the students first step into medical school. The early stages of learning in pre-clerkship, with the support of experiential learning opportunities and the same expectations on professionalism as physicians, inevitably contribute to the formation. However, it is during clerkship where students are fully immersed in the community of medical practice that they, for the most part, develop a professional identity that they resonate with. As one student summarized it:

I think professional identity is a continuous, ongoing endeavor that you keep working on. You always take in a few points here and a few points there and that comes with experience. It will come with time. Sometimes it will be steeper than the other times – getting into medical school, clerkship, residency, fellowship. But you are always learning how to build on that. (Student Participant #9)

There is also tremendous individual variation in PIF as to how that happens and at what rate it happens to students. According to one student:
I think it depends on the student and what their personality is. If you’re an independent person then you’ll develop your own independent professional identity. If you’re somebody that’s dependent on somebody else to tell you what to do all the time, then maybe you’ll end up like your preceptors. But I feel like there’s more independent people in medicine. Or at least I’m an independent person. I won’t end up being a carbon copy of one of my preceptors. I have my own identity. (Student Participant #10)

The structured MD curriculum produces graduates with similar levels on knowledge and skills. However, their understanding of the medical profession, which is based on their interests, previous life experiences, and experiences in medical school, could be very different. The knowledgableity and reflexivity of students allow them to construct meaning and identity within the boundaries. Due to this individual variation, this section not only further dissects the processes of some more common contributors to PIF, but also includes some factors that are unique to individual students, including some learning experiences in pre-clerkship.

Medical students start to identify with the identity of physicians by learning the knowledge and behaviours that insiders of the medical profession share. They mimic how physicians think, talk, and behave, and take more responsibilities as they advance in medical training. One student described learning the new language in pre-clerkship as one example of being more like physicians:

Our first few assignments in our Clinical Skills...we would practice interviewing on standardized patients and then we would type that up as a health history report. It was interesting having to go from the language that patients would use to describe things and learn how to transform that into the medical language. So I got marks taken off for saying high blood pressure instead of hypertension. And those kinds of small shifts...you essentially are learning a new language. You’re learning the language of this profession. (Student Participant #4)

Students might have their own ideas of how they want to practice medicine and how they want to approach care; their work still has to be done within the health care system. By working in the community of medical practice, students learn to work within the boundaries and make compromises to build their own expectations into their professional identities. According to one student:

I know I enjoy talking to patients...but we’re also gradually being reminded that once you’re actually on the wards you don’t have an hour to take a history. You have five, ten minutes to do everything. So I know I can’t listen as much. I know I have to cut people off at some point. And I actually wonder how I’m going to end up balancing that, where I don’t want a patient to feel like I don’t have enough time. I’m just, ‘Oh yeah, okay, interesting. What about this?’ Like developing the art of doing that I think is a part of that identity. That’s something I know I have to continue to build. (Student Participant #12)

Even though the MD program has a very structured curriculum, students still have the options and freedom to explore their interests both within and outside the curriculum. These different experiences could significantly influence their trajectories in medicine and outcomes of their PIF.
One faculty member commented on the program “Making the Links” as one of the choices for pre-clerkship students’ experiential learning and made the following observation:

The professional identity in our “Making the Links” students is going to be different than students in the general curriculum... There has been a transition towards understanding health equity and issues relevant to work in Saskatchewan, Canada, and globally that you may not otherwise be well familiar with... We have a very select group of students that would probably naturally embrace it... And more of our students go into general practice than not, which is sort of like an understated goal. (Faculty Participant #5)

Another faculty reflected on the option of the Saskatchewan Longitudinal Integrated Clerkship (SLIC) and its potential impact on students’ professional identity:

That sense of ownership and responsibility for follow up of patient care is something that our medical students don’t get as much because they move from one rotation to the next rotation. In the SLIC, students theoretically will get more of that, will begin to appreciate that, ‘Okay I ordered this bloodwork on this patient. I’m responsible for following it up. I’m responsible for calling the patient to discuss it. I’m responsible for seeing them back in clinic to follow up.’ And so for SLIC students their professional identity formation is probably a little bit different than the students who do a block-based rotation. (Faculty Participant #7)

Extracurricular activities also help shape medical students’ professional identities in many ways, especially supporting them to further pursue their interests and choose specific roles they want to fill in medicine. One student described how the involvement with advocacy for wellness of medical students was influencing her future professional identity:

...especially through the ways that I’ve been involved as an advocate for student wellness, I think I’ve realized that I’m very committed to my future profession, but I’m also very much committed to the care of myself and the care of others. And so I think that’s largely going to influence my professional identity in that I think my personal care is going to largely influence which type of practice I want to have and those further decisions. (Student Participant #1)

Another student discussed the impact of the “extra things” in building professional identity:

I went to an exchange program the summer after my first year... It’s a different world out there. I got to see the hospital there... You learn professionalism by doing extra things, so getting involved with the ministry, I did a mini project for them as well. I learned a lot of the ways of how public policy works... A lot of natural medicine is used there compared to not a whole lot of western medicine. So being able to serve people, people who don’t even know English, people who don’t know how to read and write. Just a lot of things that you might not see in Saskatchewan per say... I’m also doing another rural internship soon. I feel like those are things that have influenced me the most and helped build my professional identity. (Student Participant #9)
The “extra things” could also be factors that are completely outside of the world of medicine. Students recognize that where they were in life entering medical school and the life experiences they gained through medical school could also contribute to their professional identity. One student discussed the impact of having children in medical school:

I feel like I came into medical school with a relatively high baseline of professional identity and maturity, but I still feel like I grew throughout. I think it also helped that I had children in medical school. They helped me understand more about the other players in the system, cause I think sometimes as students we get very focused on our role. And it’s not a bad thing, but we get really focused on our dimension of care. And sometimes we fail to see that really the delivery of health care has multiple players and stakeholders, including patients and patients’ families. And then once I had children, maybe I was just better able to see how everybody fits into the picture, and that really helped me recognize my professional identity and my responsibility to other professions, to families, to children, to vulnerable patients. (Student Participant #15)

As discussed earlier, professional identity is closely related to students’ chosen specialities, which is referred to, by one of the students, as “one of the biggest life decisions”. Through seeking a specialty that is the right fit, students try to construct their professional identity. Students who know early on in their medical training which specialty they will choose have an advantage in developing a professional identity because they can focus on gaining more experiences geared towards their chosen specialty. One student reflected on this:

I got to do some extracurricular this year and really grew as a person and really immersed myself completely into the profession... Because family medicine is kind of a passion of mine. I got to help manage a group of very high-achieving individuals that were likeminded in the fact of their love for family medicine and stuff that they wanted to accomplish in the community and making a difference... There’re many days that I’m constantly thinking about, ‘Okay, what are we going to do next?’ I’m very excited about it... I got heavily involved into research. With these projects I got to network and meet physicians from all across Saskatchewan. It opened a lot of doors for me. (Student Participant #5)

This student got to experience a wide range of physician’s roles through identifying an interest in choosing family medicine as future specialty and resonating with the identity in that specialty. This gave the student the sense of “having a professional identity” even only in second year of medical school. However, for students who are uncertain about what to choose as their specialties and still exploring options, time can be a struggle because of the intense curriculum. One student discussed the lack of opportunities for self-directed learning:

I was disappointed in the lack of promotion of our individual identities. I was expecting myself to have time to take interest in unique areas or fields of medicine and have the ability to pursue those on my own time or within the structure of the curriculum. However, I feel that we’re forced to follow and learn from only the curriculum. That leaves very little time to pursue our own interests. And that leads to a lack of individuality among medical students. And with a lack of individuality, you get less unique understanding and less
motivation from a medical student’s point of view to pursue things that interest them in the medical field. (Student Participant #8)

The formation of professional identity is a long and difficult process. Students’ professional identity is never a finished product but constantly evolves with the experiences they gained through medical school. Medical students’ professional identity is very much defined by their chosen specialties. Even though there are some common learning mechanisms in medical education that contribute to PIF, students’ learning experiences can be different. The extra things that students take on outside of the curriculum and medical school could also impact their formation of a professional identity. The next section moves on to participants’ discussion of medical school’s approach to facilitate students’ learning of professionalism and PIF.

6.6 Facilitating the learning of professionalism and PIF

There is a consensus among medical students that the formation of professional identity comes less through the formal curriculum, which functions mainly to present information and deliver expectations that are not new to many. It is through the informal curriculum and the learning mechanisms identified in the above sections that students develop their own professional identities. There could be a counterproductive impact on students’ learning of professionalism and PIF if the pedagogical approaches are not executed right or if the system does not support the intended teaching. Community of practice has potential to support these two learning objectives of medical education. However, the key qualities of the community, including mutual respect and mechanism for knowledge sharing and development, need to be nurtured so that professionalism and professional identity are more present in and integrated into the curriculum.

Presenting a professional physician image and asking students to perform the physician roles can sometimes have counterproductive impact on students’ PIF. As one student explained:

I know that right from day-one, we get this linear path painted for us, which is not always very specific. And they do a good job of describing characteristics of these people. And they say that’s you. So instead of trying to help us build characteristics, I think we are just told. And by being told, it leaves less room for navigating what it means to be those things. The idea is that if we are just told enough times, that just becomes part of our identity. It doesn’t allow enough room for negotiation of identity. (Student Participant #15)

To be a professional and adopt a professional identity, students cannot take something foreign and then just be that way. They need to think about who they are and then build the universal expectations into their already established personhood. Students also voiced the concern that there were not many channels and opportunities, or mentorship for students to develop the skills needed to fulfill the non-traditional physician’s roles, for examples, leaders and advocates. One student discussed the conflicting expectations in clerkship:

I think they expect us to just suddenly transcend this, when I became a resident or when I graduate from residency. With some people I interact with, they really encourage you to speak up, give your interpretations, share your opinions. And I’m at this point where
I’m conflicted I don’t say a word because I don’t know what’s too much. It’s really uncomfortable... It sounds ridiculous but I’m at war with myself. It’s harder to learn how to tailor your personality in an appropriate sense to this very regimented boxed requirement of a med student. And to stay within that until the point where you’re actually allowed to get out and suddenly be this full-fledged assertive, appropriate physician. (Student Participant #14)

This example illustrates that developing a professional identity that performs the different physician roles is expected but not nurtured or even sometimes discouraged in medical training. This can create an identity conflict for medical students. The missing of mentorship can leave students feeling confused and struggling. The student from the above example further commented:

That insider perspective is really what I need. I don’t need someone who can talk about ideals and principles and the seven roles of a medical professional. I know them and I’m trying to exhibit them but the hows of it is a lot harder than it sounds. (Student Participant #14)

The environment does not provide sufficient opportunities or mentorship for students to practice the non-traditional roles of physicians. Therefore, they feel the need to take initiatives and be conscious to put effort into that aspect of learning. While it illustrates the consciousness on the part of some students, it also identifies a gap and deficiency in the curriculum. The non-traditional physician roles become a less and less priority for students when the informal curriculum does not support or devalues the learning on them. The College so far does not have a coordinated or cohesive approach to support medical students to develop a professional identity. One faculty member commented on the “medical tourism” nature of some of the learning opportunities at the college:

We have a lot of students who like to go up north. The Saskatchewan Medical Association takes them on tours to some of the northern communities. But a lot of that feels more like medical tourism to me. It’s like, ‘Oh, I’m going to get to go to La Loche or I’m going to get to Stony Rapids’. But I’m never quite sure if some of those things are teaching the kind of connection that you need to have with a community to really do meaningful work. (Faculty Participant #9)

The scattered learning opportunities make it difficult for students to see the overarching objectives and the connections among these opportunities. This lack of connection has a significant impact on their learning and behaviours.

It is recognized that learning of professionalism and professional identity is both important for individual medical students and the progress of the medical profession. Faculty and students also reflected on how to best to approach these topics and facilitate the teaching to be more effective and learning more supportive. Instead of framing professionalism as a list of individual behaviours, professionalism could be seen as a relationship. Even though guidelines could be provided, professionalism is not a static list of things to do. It is very dynamic and changes with situations and contexts. According to one student:
I don’t think that professionalism is something you can just tell somebody, like, ‘You need to be professional and this is what professionalism means’, because every situation that you’re in may call for a different level of professionalism just based on the person that you’re dealing with and the situation specifically. So I think that a lot of it is you just learn based on what you see and you have to learn from how others react or respond. (Student Participant #7)

Through recognizing the strengths and weaknesses in the people that students work with, they can piece together what professionalism means and calls for in different contexts. Understanding professionalism from the relationship approach could also help students understand physician roles, which contributes to their PIF. One faculty discussed how the relationship with patients could help students develop their professional identities and such learning experiences need to be explicitly provided:

I think we probably don’t think about it (professional identity) that much explicitly in medical school...we don’t think about how important it is, and how much time and effort needs to be devoted to shaping and forming medical students’ professional identity... Even the whole idea of communication with patients and patient- and family-centred care, there’s whole lot more that could be done to explicitly work with students to think about and examine from their own perspective ways of treating patients, particularly those that are marginalized and how our thinking effects communication. (Faculty Participant #1)

The structure of medical education allows students to work and learn within a community of practice. Medical education centres around role modelling in theory, but does not put enough emphasis on it in reality. Teaching the important dimensions of medical professionalism through lectures and guidelines is the easier way, not only in content delivery but also in evaluation of students. Teaching through modelling, observation, and mentorship, which is effective and has long-term impact, requires time and efforts on both individuals and the education system. One faculty discussed the value of role modelling in teaching students to recognize their privileged position in society and the responsibilities of physicians:

You can’t get paid really well and not have obligations that are above what most other people have in their work. You can’t be trusted to do the things you do with patients without having an incredible sense of dedication and commitment and concern and compassion and all of those things. Because it is such a privileged role in society. I mean the role modelling I think becomes really important. I think having courses that talk about these things is really important. But it’s not about the talking. It’s about doing and about recognizing the privileged place you have and the responsibility that goes along with that. (Faculty Participant #9)

Experiential learning, combined with mentorship and reflection, could potentially narrow the curriculum gap. Reflection is a significant contributing factor to PIF. Even though students believe self-reflection is more effective than forced reflective assignments, self-reflection could be enhanced when they feel comfortable to have discussions with mentors and peers. Students encounter new experiences, which can be emotionally challenging, on a daily basis that shake their perceptions of medicine and life in general. There should be safe space and realistic
expectations around confidentiality that allow students to reflect on progress and mistakes, and receive support when needed.

One alternative approach for students to understand the bigger picture of what medicine could offer in society and how physicians fit in society is to provide opportunities to see medicine outside of hospitals. One faculty advocated for more outpatient experience to be included in the curriculum:

So more ambulatory care clinics. Even incorporating it to home care and doing rotations. For example, home care, it’s very different to see people in their own environment because they’re more comfortable and then you can get a better context of what they’re actually dealing with. You get this sense when you work in the hospital that everything exists in the hospital… That’s a detriment to care… the language of having community and hospital as completely separate entities. (Faculty Participant #6)

Medical schools could also have mechanisms to teach students to take social histories of patients, which is crucial for good patient management. Another faculty suggested an approach for medical students to perform the role of advocates through community engagement:

And it probably even goes beyond these things. I think there’s things that you need to know about community engagement as a physician that we probably don’t even teach very well. I have never lived anywhere where the number of people who don’t wear a bicycle helmet – it blows me away. I think being an advocate is a huge part of being a physician. Why isn’t there anyone advocating in this province for people to wear their bicycle helmets? So there’re all kinds of things that I think we could be doing to nurture the kind of characteristics and the kind of identity formation that you would like them to do. But I’m just not sure we think about it enough. (Faculty Participant #9)

These opportunities do not need to be created or invented; they already exist and are based on the needs of the population. Having a consistent presence in the curriculum, these concrete activities could allow students to not only appreciate but also perform the different dimensions of professionalism and physician roles. The goal is to ensure that the roles that are not the biomedical expert get incorporated into the professional identity of medical students.

6.7 Chapter summary

Clerkship is a crucial stage in medical education that provides many learning opportunities for students to perform professionalism and identify as a physician. This chapter has addressed some of the common learning mechanisms in clerkship, including role modelling, patient encounter, fitting into the environment, and self-directed learning and feedback. These learning mechanisms allow students to work closely with physicians in the community of medical practice and be a part of the team to care for real patients. Professional identity becomes important in clerkship as students gradually negotiate their position in the community when they gain more knowledge and skills. Students experience the learning and working environments in different specialties and develop a better and more realistic understanding of the various competencies required and different roles that physicians need to play to provide good patient care. They further develop a
specialty-related professional identity that resonates with their values and interests. Even though there are common learning mechanisms in clerkship, the process to form a professional identity is very individualized and has to be based on students’ interests in medicine and their unique understanding of the medical profession.

Curriculum gaps were identified in several areas to have a counterproductive impact on students’ learning. Though students gain more appreciation for the non-medical expert roles through clerkship, there is no expectation for preceptors to teach or for students to progress on these competencies. Tacit knowledge in clerkship is an important channel for students to learn professionalism; however, because what is preached is not always what is practiced, it can also significantly undermine the purpose of the formal curriculum. The goal of medical education is to train medical students to be physicians to perform a full spectrum of physician roles and provide health care that is patient- and family-centred and interprofessional. However, students are trained in a health care system and a community of medical practice that do not always value or practice these models and mostly only observe physician perform the role of medical expert and communicator in clerkship. The resistance to change for a better health care continues to be pervasive. Students do not have the motivation to pursue learning on these competencies or advocate for change due to their vulnerable position in the medical hierarchy and the competing priorities in a busy and stressful MD program.

Medical school has a role to play in facilitating students’ learning of professionalism and PIF. To support the changes in health care services that patients need and deserve, medical schools need to provide opportunities for students to experience the roles of physicians so they internalize them as their responsibilities and develop the required competencies. The next chapter, “Discussion and Conclusion”, explores the findings through the theoretical framework and key theoretical concepts identified in Chapter 3. It integrates students’ learning experiences from pre-clerkship and clerkship chapters to interpret what these findings mean for medical education moving forward. It will conclude by discussing the contributions and limitations of this study.
CHAPTER 7 DISCUSSION AND CONCLUSIONS

7.1 Introduction

In this last chapter, I apply the theoretical approaches highlighted earlier in the theoretical framework and methodology chapters to analyze the findings presented in the two preceding chapters. In 7.1, drawing upon IE’s emphasis on texts and how they organize participants’ actions, I discuss the socially constructed nature of the concept of professionalism and the importance of defining professionalism in a comprehensive way. In 7.2, utilizing community of practice theory, I situate medical students’ learning in the communities of medical school and medical practice and discuss the importance of informal learning and tacit knowledge in medical education. A theoretical explanation of students’ PIF, which is based on a more realistic understanding of professionalism and physician roles through legitimate peripheral participation, is also provided. In 7.3, using the concept of knowledgability and taking into consideration power relations in medical school and medical practice, I analyze the interplay of structure and agency and the process of structuration of the dominant discourses of competency and standardization in medical education. By highlighting the curriculum gap, I also underline the impact of resistance to change from inside the medical communities. Following these three sections, I discuss the place of professionalism and PIF in medical education moving forward to provide some practical implications of the findings for both medical education and medical education research. I then discuss the contribution and limitations of this study before providing a few conclusions of the study.

7.2 The socially constructed concept of professionalism and importance of defining professionalism in medical education

Much more than a list of appropriate behaviours and attitudes, professionalism is a value-laden term that carries societal, institutional, historical, and contextual expectations (Martimianakis, Maniate, and Hodges, 2009). The values, attitudes, and characters of a good physician largely depend on the goals of medicine and the function the medical profession serves in society, which are fundamental questions to the PIF of new physicians (Kenny et al., 2003). The teaching and learning of professionalism at the CoM have important theoretical implications for the understanding of the concept. The fact that three types of professionalism (student professionalism, professionalism in professionals, and medical professionalism) are identified in this study further illustrates that professionalism is socially constructed not only at the societal level but also at the institutional level.

Texts play an important role in medical school in regulating human behaviours, including those of students. The replicable and constant features of texts make them an integral feature of institutions (Quinlan, 2009). However, not all texts have the same status or exert the same impact on participants. Two types of texts that are relevant to professionalism and professional identity are revealed in this study. The first one is abstract, serving to identify guiding principles. The CoM’s statement on professionalism (whether it is developed by the institution or borrowed
from other organizations) and MD program objectives would fall under this category. This first type needs to be materialized by the second type of texts, which are more concrete and detailed, and have specific standards to which participants need to adhere. The CoM’s professionalism policies and procedures and course syllabi belong to the second type.

The importance of the topic of professionalism is made explicit in both the first and second types of texts with the first type focusing on medical professionalism and the second emphasizing student professionalism and professionalism in professionals. However, in the first type of texts, the content with regards to professionalism simply exists without the CoM providing any kind of rationale for their existence or drawing connections between the different sources of texts. They are not explained with regards to how the CoM is fulfilling the commitment to medical professionalism in practice or expectations for medical students. This is made more explicit when one of the components in the CoM’s statement on professionalism – CMA Code of Ethics – was not updated long after the CMA itself updated the document to Code of Ethics and Professionalism. The documents in the professionalism statement have a presence on the CoM website and are briefly mentioned during orientation to signify that the CoM has fulfilled its teaching commitment related to the standard of professionalism. They are not enforced in the daily practices and therefore serve mostly symbolic functions.

The second type of texts, on the other hand, are strictly enforced by both the faculty and students. The CoM’s development of the professionalism policy and its listing of professionalism as a distinct item in many other policy documents, including course syllabi across all years, have become institutionalized over the years since its establishment. This is done through the standard approach of explaining these policies and providing similar examples during the first-year orientation, and repeating them at the beginning of the rest of the years. The definition of professionalism is further narrowed when the policies and procedures are explained to students and only certain aspects related to student professionalism and professionalism in professionals are mentioned. Minor adjustments have been made to include students’ feedback such as changing the label from professionalism breach to professionalism incident. However, the mechanism of how incidents are reported and handled remains the same and the minor adjustments have made little to no change to students’ attitude toward the professionalism policy.

The CoM, as an institution, has a lot of power in transforming the first type of texts into the second type. Because of this, understood from the IE perspective, students’ daily learning experiences have an institutional nature. Specific instructions are provided on how faculty and administrators should report a professionalism issue, who the students are to meet, and how to resolve the issue. For example, even though a student is one minute late in submitting an assignment, no excuse will be considered. The event, labelled as an incident, has to be documented and resolved through the process identified by the institution. While it is said that the policies and procedures are guided by the principles in the professionalism statement, the content in these documents mainly lists and provides examples of unprofessional behaviours. It is made evident that the CoM does not focus on promoting professionalism but identifying and correcting unprofessional behaviours to protect the College’s image and reputation. The
development and strict enforcement of these policies and procedures on professionalism have
directly contributed to students equating the concept of professionalism to not submitting an
assignment late or not missing a mandatory session. By defining and activating the concept of
professionalism in the local context, the CoM produces a discourse of professionalism that
incorporate only student professionalism and professionalism in professionals.

Students’ reflections have revealed the impact of these institutional practices on their lived
experiences as medical students. The impact is made more powerful when students’ learning
happens in a hierarchical environment that has consistently taught them that they are under
scrutiny at all times. Even though faculty try to explain their relationship with medical students
as being an ally to them, students are acutely aware that they are in a very vulnerable position
and have framed the relationship as ‘us versus them’. Professionalism is understood by students
as a significant criterion, based on which people who have authority and power could decide
whether they are suitable for the medical profession. The fear of being labeled as unprofessional
or having a professionalism incident is very real for medical students. The situation is made worse
when students observe and learn that the professionalism policies apply only to students but not
faculty. Therefore, the CoM’s approach of teaching professionalism is not only not effective, but
also has an unintentional and counterproductive impact on students. They become cynical about
anything related to professionalism and choose the approach of putting on a show and just
dealing with it for the sake of getting through medical school. In a way, students are not learning
to be professionals; they are learning not to be or be labelled as unprofessional.

When professionalism is taught through the medical professionalism lens in pre-clerkship, mostly
in Medicine and Society, it is taught in a linear pathway, generally in lecture forms with limited
experiences in communities. Participant observation reveals that it is very rare that instructors
explicitly discuss the socially constructed nature of professionalism, the ambiguity of the concept,
or the conflict between the listed ideals and students’ observations in practice. The formal
curriculum such as the CanMEDS framework explicitly states that the seven physician roles are
the necessary competencies that MD students should have. However, in the informal curriculum,
the learning outcomes are identified by the CoM as simply explaining, describing or identifying
the importance of these roles instead of acquiring or performing these roles. The assessment of
these courses, again, relies on students reflecting on how these roles are potentially relevant for
their future practices. The gap between teaching students to ‘do’ and to ‘know’ illustrates that
students are not provided the opportunities to learn the skills to ‘do’ or acquire the identified
necessary competencies. Despite the CoM’s emphasis on the CanMEDS framework, its
institutional practices, in reality, continue to undermine the value of the roles that physicians
need to play to provide quality health care other than the medical expert role. Because of the
gap, students find the M&S courses easy to pass and do not want to ‘waste’ their time on these
courses. As an institution, the CoM can significantly influence and shape medical students’
understanding of professionalism through defining and teaching it.

The analysis of the CoM’s institutional practices on professionalism issues, with a specific focus
on texts, reveals the gap between the formal curriculum and the informal curriculum – the
disconnect between what the medical school intends to teach (should teach) and what it actually

168
teaches. From students’ perspective, professionalism at the CoM is understood and practiced in policy and procedural forms. Institutional practices, guided by texts and the implications of texts, emphasize certain aspects of professionalism and devalue some other aspects. The CoM includes the aspects or levels of professionalism that are easier to define, monitor, and regulate when transforming the formal curriculum into the informal curriculum. These institutional practices make the understanding of professionalism very static and one-dimensional and ignore the fluid and dynamic nature of it.

The nostalgic view, which emphasizes individual motives and behaviours, has dominated the modern-day discourse on medical professionalism, which has unfolded through discovering, defining, assessing, and institutionalizing medical professionalism (Hafferty & Levinson, 2008). According to Hafferty and Levinson (2008), we are slowly shifting towards linking agency and structure, and recognizing and modifying the underlying structural and environmental forces that significantly shape social actors and actions. The results from this IE have found that on professionalism issues, the CoM has not advanced beyond the practice of discovering, defining, assessing, and institutionalizing (Hafferty & Levinson, 2008). It focuses on aspects of professionalism that could easily be discovered and defined (modified from organizational or other institutional documents) and assessed (developed as institutional policies and procedures). These practices fail to acknowledge the impact of the structures of medical education on learning or the knowledgeability and agency of medical students. The narrowed definition of professionalism focuses on regulating students’ behaviours and limiting the risks that could potentially damage the college’s reputation. It does not result in transformative learning and has a counterproductive impact on students’ future engagement with the concept of professionalism.

Professionalism in medicine should not just be understood as the individual conduct of professionals. The functions of professionalism and why it exists in medical practice need to be explored in medical education. Professionalism serves as the basis of the social contract between medicine and society (Swick, 2000). Public trust in physicians, which is dependent on the integrity of both individual physicians and the medical profession as a whole, is essential to the social contract (EFIM, 2002). Medicine, as a profession, is granted autonomy in practice, the privilege of self-regulation, and financial and nonfinancial rewards. In return, physicians are expected to assure competency and be devoted to the public good of improving the health and well-being of the population (Parsons, 1951; Freidson, 1970; Sullivan, 2000). Interpreting professionalism through this lens underlines the relevance of professionalism to the practice of medicine and makes it easier to understand the profession’s obligations and the reasons for their existence (Cruess & Cruess, 2008). It also identifies the parties in shaping the social contract – patients, the public, and government of the medical profession, the collective expectations of which constitute a functional definition of medical professionalism (Cruess & Cruess, 2008). This approach of defining professionalism emphasizes the role of societal expectations in forming the relationship while also leaving room for medical professionals to negotiate the contract. Moreover, it highlights that professionalism is not a stable construct that can be isolated, taught, and evaluated; instead, it is socially constructed in interaction (Martimianakis, Maniate, and Hodges, 2009). A comprehensive discussion of professionalism must also include its impact on the
incoming physicians and medical students (Martimianakis, Maniate, and Hodges, 2009). Medical students and practitioners cannot just be told what professionalism is or how to behave; they need to be a part of the conversation in developing a collective definition of professionalism.

Rapid advances in knowledge have dramatically changed the nature of professions, especially medicine. Professions, including medicine, have become more deeply linked to the development and application of expert knowledge and less closely connected to the functions of the professions, which are central to the good of the public and society that professionals serve. Brint (1994) considers this to be the rise of ‘expert professionalism’, which has paralleled a decline in the traditional ‘social-trustee professionalism’ in an age of experts. Partially due to this, physicians practice in the midst of public dissatisfaction, calls for health care reform, and increased patient activism and advocacy (Walsh & Abelson, 2008). Looking ahead, technology will represent many transformations in all aspects of care, which requires that physicians have the knowledge and skills to interpret vast amounts of data and communicate with patients and families in effective ways (Cirillo & Valencia, 2019). Personalized medicine will become an important concept as patients expect care (e.g., treatment and medication) to be tailored to their needs and preferences (Goetz & Schork, 2018). Teaching and learning on cultural competency and cultural awareness continue to be challenging for medical schools despite the formation of it as a standard in 2000 (Worden & Tiouririne, 2018). These are only a few of the aspects that should be considered in defining a professionalism that could facilitate the medical profession to fulfill its promises to society. Without a clear understanding of the goals and function of medicine, medical school cannot sufficiently facilitate learning that would inform medical practice that patients and society expect (Kenny et al., 2003).

The physician charter that defines medical professionalism in the new millennium, which includes the three fundamental principles of primacy of patient welfare, patient autonomy, and social justice, is a good example to illustrate the importance of collectively fulfilling the function of medicine (EFIM, 2002). None of the three principles could be realized by the efforts of individual practitioners; instead, they require the efforts from the medical profession and collaboration with other stakeholders in the health care field. For example, the individual quality of altruism is important for good doctor-patient relationships, which contribute to patient welfare; however, market forces and administrative pressures could significantly compromise the quality of patient care. Mechanisms have to be put into the system to support physicians to serve the interest of patients first. Similarly, it is not realistic to present the principle and ideal of social justice to medical students in school and expect them to fully embrace and practice that after graduation. Alternative learning approaches, especially experiential learning and transformative learning, as well as role modelling, need to be strongly emphasized to support students to identify with the missions of medicine and acquire the knowledge and skills to fulfill the missions.

The results from this study are not to suggest that student professionalism and professionalism in professionals should not be paid attention to or regulated by medical school and medical educators. Rather, I argue that they should not be the only or the most important channel of talking about professionalism, in either written or verbal format. It is not problematic to list professional as a distinct competency and one of the physician roles, as there are ethical
dimensions of medical practice that need to be considered to ensure that physicians work within professional boundaries. However, it is problematic to understand and teach professionalism only as it relates to the role of professional, which is the current practice. Professionalism explains why and how the various physician roles exist to guide medical practice and consequently medical education. Therefore, professionalism should be utilized as the overarching framework to understand the concept of physician role.

The socially constructed nature of professionalism (at both societal and institutional levels) makes it crucial for medical schools to consider their approaches in defining and teaching professionalism. According to Hafferty and Levinson (2008), “...professionalism has no meaningful existence independent of the interactions that give it form and meaning. There is great folly in thinking otherwise” (p. 611). Medical education is a complex adaptive system; so are issues on medical professionalism. Both need to be understood from the view of complexity science, which seeks to acknowledge and understand the interdependent and interactive nature of social structures, social actors, and environmental factors (Hafferty & Levinson, 2008). Framing the discussion of professionalism in broader sociological terms, especially connecting it to its dependency on societal expectations and its evolving nature through negotiation among stakeholders, has significant implications for medical education and medical practice. The next section moves on to the concept of professional identity by situating medical students’ learning within communities and discusses the importance of tacit knowledge and informal learning in medical education, especially during clerkship.

7.3 Community of practices, tacit knowledge, and identity formation

The theory of community of practice emphasizes the community environment of learning and the nature of learning as social practice, contending that identity becomes significant when students learn in a situated community. In both pre-clerkship and clerkship, medical students learn within the communities of practice. In pre-clerkship, their learning community includes mainly instructors, peers, and standardized patients. Medical students hold the primary identity as a learner, which requires them to possess a large amount of knowledge. They only get a glimpse of the workings of the medical profession through shadowing and observing physicians’ work. The frequent opportunities for medical students to work together with peers help construct a community of individuals with the same interest in and goal of pursuing medicine. Their extracurricular activities also tend to be medicine-related when they try to build their resumes and networks in medicine. Moreover, medical students are more likely to socialize with other medical students. Because of the people and the events that they associate with, medical students come to build an identity in which everything revolves around medicine. The expectations of people within and outside the medical community also shape the construction of medical students’ identity. Faculty tend to think that students have been hired and they are learning on the job, and families and friends tend to treat medical students already as an expert. Even though medical students are not physicians yet, they earn a social status that is similar to physicians.
Entering medical school gives medical students legitimate status of pursuing the enterprise of medicine. However, in pre-clerkship, medical students are not directly involved in patient care and primarily work with preceptors and peers to practice their clinical skills with standardized patients. Therefore, their identity mostly revolves around the student identity but not the professional identity. As medical students advance in their training, they increasingly approximate physician identity. However, each level of medical training has its own identity. Therefore, medical students are not just learning to be physicians; they are also learning what it is to be medical students (Jarvis-Selinger, Pratt, & Regehr, 2012). At this stage, though students might have a preference for a specialty they would like to go into, they have not learned the variety of practices that medicine has. They might identify with the identity of physicians but they have yet to align themselves to a professional identity that is associated with a specialty. The uncertainty of this further contributes to students’ hesitancy to say that they have developed a professional identity.

In clerkship, preceptors (residents and attendings), other health care professionals, and patients constitute medical students’ learning community. In contrast to pre-clerkship, clerkship students are fully immersed in the community of medical practice on a daily basis and provide direct care as members of the health care team. At this stage, they learn through peripheral participation under supervision and learn by doing the physicians’ work. In clerkship, medical students learn not in a classroom but at the workplace, which makes clerkship situated learning (Lave & Wenger, 1991). In clerkship, students learn the application of knowledge and skills to a patient with a problem that may or may not be solved by the abstract knowledge they have learned in pre-clerkship. Students need to make adjustments based on the needs of patients and the immediate work environment, and collaborate with other team members. Therefore, learning in clerkship, as a social process, is situated in a structural and cultural context and takes place through leaners’ participation in social practices to pursue an enterprise (Lave & Wenger, 1991).

Community of practice is essentially a type of informal learning (Li et al. 2009), which is not strictly structured and depends heavily on participants and the interactions among them. The key element of community of practice does not lie with a group of people; rather, it defines a social process of participants negotiating competency in a domain over time (Farnsworth, Kleanthous, & Wenger-Trayner, 2016). Communities provide the foundation for sharing knowledge and a safe environment for novices to engage in learning through observation of and interaction with experts (Li et al., 2009). Being on the wards on a daily basis gives medical students frequent opportunities to observe physicians work. For example, through observing the day-to-day routines, students see how physicians practice patient-centered care by listening and acknowledging patients’ concerns or making sure patients’ privacy is protected in real-life scenarios. Furthermore, in clerkship, medical students legitimately participate in peripheral learning activities and move from low-risk and simple tasks to more complicated tasks. The interactions between novices and experts, as means, allow novices to identify gaps in their knowledge and skills. The recognition of the gaps, together with medical students’ desire for more responsibilities and full participation, motivate learning (Lave & Wenger, 1991). By providing direct patient care, students gain a sense of fulfillment that contributes to their PIF in that they are performing the role of physicians. With more knowledge and skills, they take on
more responsibilities and become more proficient with the vocabulary and tacit knowledge of their professional community. They also associate themselves increasingly strongly with the identity of the community as they continue to interpret and reinterpret themselves as members of the community (Jarvis-Selinger, Pratt, & Regehr, 2012).

As opposed to merely acquiring knowledge and skills, negotiating meaning and becoming a certain person within a social context is at the core of human learning (Farnsworth, Kleanthous, & Wenger-Trayner, 2016). When medical school teaches students the knowledge and skills to be a competent physician, it also invites students into an identity for which those types of knowledge and skills represent a meaningful way of being (Farnsworth et al, 2016). The focus on identity in the community of practice theory creates a tension between competency and experience, and adds a dimension of dynamics and unpredictability to the production of practice as each member struggles to find his or her place in the community (Wenger, 2010). Medical students’ PIF represents their changing ways of participating in a practice and involves a movement through a series of distinct developmental stages, which are characterized by differences in understanding one’s environment and one’s place in that environment (Jarvis-Selinger, Pratt, & Regehr, 2012).

The rapid turn-over of learning environments during core clinical rotations gives students a taste of medicine’s different specialties. Students provide service on each rotation as a way of learning, absorbing and being absorbed into the culture of each specialty. Through this process learning becomes a social practice that is integral to medical education (Johnson & Pratt, 1998). As medical students’ professional identity is largely defined by their chosen specialty, clerkship is a crucial period of students’ PIF. They not only continue to learn and apply the specialized knowledge and skills on each rotation, but also have a chance to understand the working environment of each specialty (e.g., the patient population and work pace). These two components help them decide which specialty is the right fit and whether they can succeed in that specialty moving forward. In clerkship, medical students slowly construct their professional identity by locating a place within the medical community that they are comfortable with and to which they can make a contribution.

Medical students also have a better and more realistic understanding of the medical profession through participating in the community. The traditional characteristics of caring and altruism still hold true for the future generation of physicians. There are, however, many other intangibles – soft skills of medicine – that students come to realize are crucial to provide good patient care. These include managing interpersonal relationships, developing good rapport with patients, and understanding the whole spectrum of health and care, which are as important as learning information and applying them to clinical scenarios. Working in the community and getting feedback from preceptors have allowed medical students to care in an appropriate way. For example, as much as some students enjoy the parts of medicine that involves interactions with patients, working in the hospital has taught them that they have to see multiple patients in a very limited time. This requires them to strategically direct their questions and lead patients to provide more information in a more efficient manner. Coming to appreciate the complexity and uncertainty of medicine further contributes to medical students seeing medicine from a
physician’s perspective, and identify and associate with the side of physicians instead of laypeople or patients.

Medical students go through the three modes of identification categorized in the community of practice theory: imagination, engagement, and alignment (Wenger, 2010). They build their own expectations for medical school at different stages (e.g., before they start pre-clerkship and clerkship) and then engage with different players in the community to gain some lived experiences. As they engage in the community, they also construct an image that helps them understand how they belong. By reflecting on their situations and exploring new possibilities, they see themselves from a different perspective to locate and orient themselves (Wenger, 2010). The alignment, which depends on imagination and engagement, and requires students to adjust their expectations and work within the boundaries, contributes to a more realistic understanding of their chosen profession.

In clerkship, students test, revise, and integrate their prior understanding of the medical profession through application. What they take away from learning is dependent on the contexts in which it is learned. Students’ immersion in the clinical environment is so pervasive in clerkship, which allows them to build increasingly complex frameworks of the practice of medicine by learning both the content and context, and both the product and process (Johnson & Pratt, 1998). It takes time and experience to transition from one stage to another. However, the transition is also accompanied by emerging crises, which result from discrepancies between students’ previous perceptions and the immediate experiences and challenges that they face. The new information forces students to re-examine old choices, values, and perspectives, and develop a new and more realistic understanding of themselves and the medical profession.

These crises represent both increased vulnerability and heightened potential, and deserve attention from medical educators to support learners to navigate the transition (Jarvis-Selinger, Pratt, & Regehr, 2012). This is especially important in clerkship as it involves a significant level of informal and self-directed learning. PIF is a complex developmental structure that a learner uses to relate motivations and learned competencies to a chosen professional role, and therefore context, community, and relationships play a role in the process of identity formation (Wilson, Cowin, Johnson, & Young, 2013). PIF synergizes the cognitive and interactional processes in the institution of medical school as medical students develop their identities (Monrouxe, 2010). It is ultimately a process of socialization when students are immersed in medical school and the clinical environment. The socializing agents – preceptors, peer groups, and patients – all play a part in the process of socialization.

A significant source of competency is the tacit knowledge that students observe and learn during medical school. Seeing how people surround them practice and treat each other, and how they themselves are treated, medical students tend to internalize and perpetuate the patterns of behaviour (Inui, 2003). For example, though no one deliberately tells them, medical students learn to use the term hypertension instead of high blood pressure or put the other hand on a patient’s back when using the stereoscope. Tacit knowledge can serve a functional channel, through which students gain proficiency and confidence in their application of knowledge and
skills, and interactions with patients and other health care professionals. However, tacit knowledge could also easily have counterproductive effects on students’ learning. Faculty may be unaware of some of the gaps between the widely recognized manifestations of virtue in action and what they actually do in the circumstances of reality; however, even when aware they can be silent or inarticulate about the dissonance. In being unaware of the gaps or staying silent, they miss opportunities to assist medical students to understand the challenges when attempting to live up to the ideals of the medical profession (Inui, 2003). The informal curriculum in clerkship can easily contradict the ideals preached in the formal curriculum. The informal curriculum, which is based on students’ lived experiences of observed practices, has a more influential impact. As expectations on health care delivery change rapidly, particularly with respect to interprofessional practice and patient-centered care, formal curriculum that conflicts with what students observe in practice may be dismissed.

Tacit knowledge cannot only be seen as a product or outcome; it is also a process in medical school that defines essential knowledge and devalues other forms of knowledge. The definition of tacit knowledge emphasizes the feature of participants not being able to verbally articulate what they know or explain why they behave in certain ways. However, I argue that another feature – intentional avoidance – should not be underestimated. The findings from this study reveal that in many instances when specifically asked, participants could articulate why they hold a certain perspective or why they approach a situation or problem in ways that are in contrast to guidelines or best practices. They simply do not encounter a lot of opportunities that warrant their reflection or explanations of their behaviours. This further underlines that knowledge is bifurcated in medicine and medical education. There is explicit knowledge that students can legitimately ask questions about and preceptors are expected to provide answers to (e.g., questions about disease presentation and treatment plans). Tacit knowledge is not substantively included in the informal curriculum, and students are often reluctant to engage preceptors on these questions, such as ethical dilemmas and competency in physician roles apart from medical expert. By categorizing these types of knowledge as tacit knowledge, medical education further devalues their relevance to medical practice, which leads to students’ lessened interest in these topics and hesitation to engage in these types of informal learning.

The CoM and medical educators are proposing a professional identity that has different dimensions, including the medical expert, communicator, collaborator, leader, health advocate, scholar, and professional, in the formal curriculum and some of the informal curriculum in pre-clerkship. However, in clerkship, when students are exposed to knowledge and skills application, they mostly see the application of the role of medical expert and do not see many physicians who perform the non-medical expert roles. When there are situations that involve physicians practicing the non-medical expert roles, there is no expectation that preceptors will explain or students will ask why things are done in certain ways. The ‘hows’ of performing the non-medical roles are not explicitly taught or learned. Students’ lived experiences have revealed that they encounter events that challenge their understanding of medical professionalism and physician roles on a fairly frequent basis; however, these real-life scenarios are not fully utilized or utilized at all to support and encourage students’ PIF.
The community of medical practice holds unique characteristics that could either promote or inhibit students’ development and adoption of a professional identity that meets societal expectations. Both the student and the medical professional have a responsibility for professional identity development. Attention must be paid to the quality of the community of practice to support students to experience a successful trajectory into PIF (David, 2006). Medical school needs to acknowledge – be explicitly mindful and articulate – that medical education, especially clerkship, is a process of personal and professional formation. This process is deeply rooted in the daily activities of individuals and groups in the community of medical practice. A strong learning environment with the conditions of mutual respect and trust, and a structure and mechanisms for members to share ideas, could support learners to make sense of new knowledge. Medical educators need to work with learners to actualize positive learning environments that are transformative to support the formation of a professional identity that is healthy and sustainable (Wald et al., 2015).

7.4 Knowledgeability, power relations, and structuration

The concept of community of practice emphasizes learning in its social dimensions and a community of practice is in itself a social learning system (Wenger, 2010). It exhibits many characteristics of systems in general and is well aligned with the perspective of the systems tradition with its complex relationships, dynamic boundaries, and ongoing negotiation of identity and cultural meaning by participants (Wenger, 2010). Learning is a production of social structure and, through participation, the social and the individual constitute each other. This section specifically discusses the interplay of agency and structure in medical school.

The duality of structure underlines the mutual dependence of structure and agency (Giddens, 1979). On the one hand, social structures are drawn upon by human agents to constrain or enable interaction. On the other hand, the actions of individuals in social contexts function to either reproduce or change social structure (Giddens, 1979). Medical school is a knowledge-based institution and is comprised of daily social interactions that involve situated activities of human agents. Their activities are situated within a community and constituted by regular and reproduced relations of interdependence between either individuals or collective groups. Structures that are put in place in medical school define the patterns of social relationships, which are accompanied by rules and guidelines in policies and procedures, and result in producing knowledge of how things should be done and enduring practices in the community.

Students’ reflections reveal how their experiences are recursively organized by the structure of medical school and the CoM’s recurrent institutional practices. Professionalism not only plays a role in society in providing social good, but also serves the function of social control in medical school by having it as an evaluation standard (Martimianakis, Maniate, and Hodges, 2009). Medical school, in which this study is conducted, represents certain patterns of behaviour within a specific hierarchical setting. Through both texts and unspoken rules, utilized in practice to reward ‘rights’ and correct ‘wrongs’, these patterns signify to students the way things are done. Even though minor changes are made, the hierarchical structure, regularized relations of interdependence, and imposed control of medical students remain the same through the
establishment and application of generative policies and procedures. The status quo is reproduced by participants, including faculty, administrators, and students, all of whose work and actions are constrained by institutional pressures of administrative convenience and standardized practices.

The concept of locality and lived experience in Smith’s understanding of IE corresponds to the flowing nature of action in Giddens’s (1979) definition of agency: “a stream of causal interventions between corporate beings in the ongoing process of events in the world” (p. 55). This perspective also underlines the reflexivity and knowledgeability of human agents. Because individuals cannot construct reality from scratch in any given community, they draw upon pre-existing structural elements in their actions (Timbrell, Delaney, Chan, Yue, & Gable, 2005). In order to draw upon the pre-existing rules and resources, actors need to be knowledgeable of what rules are appropriate and what resources are available. Through immersion in the community, observation, and interactions with other groups of participants in medical school, students are able to rationalize some of their actions explicitly. For example, with the expectation to be devoted to their chosen profession, medical students actively organize their extracurricular activities to be medicine related and build their network to be well connected in the medical community. They learn in medical school that these aspects are important for their residency application.

At the same time, they also acquire non-discursive knowledge of the contexts and conditions of their actions, which are tacit stocks of knowledge that they draw upon to constitute their social activities involved in learning as a social practice. Knowledge is not always available to individual conscious awareness and the practice and production of non-scientific component of activities also qualifies as knowledge (Pleasants, 1996). This understanding of knowledge from the shift of intentional cognition to practice underscores that knowledge is not just a product or state. It is also understood in terms of process and activity, which means individuals are knowledgeable actors and experts in what they do. As suggested in Polanyi’s (1967) statement that “we know more than we can tell” (p. 4), knowing does not often “entail a corresponding discursive or propositional facility to say how, or what it is that one knows” (Pleasants, 1996, p. 234). For example, even though medical students know that it is not right to talk behind patients’ backs and no one has deliberately told them, medical students learn to add in a comment or laugh at someone’s joke when physicians talk badly about patients. Students do not feel they have the authority to challenge those who are above them in the medical hierarchy and they have to fit in the environment, which is equally important as learning in clerkship.

Knowledgeability is not just information; when participants are situated in a landscape of interrelated practices, it is “an experience of living in a landscape of practice and negotiating one’s position in it” (Farnsworth, Kleanthous, & Wenger-Trapner, 2016, p.4). Students are knowledgeable about how to become a successful pre-clerkship medical student and do well in clerkship. During pre-clerkship, they understand the main goal is to pass exams and the subjects that are more difficult are the biomedical science courses, which contain more information and require more time to memorize the content. Time is one of the most important resources that students have and could utilize in medical school. Therefore, they develop strategies to spend as
little time as they can on social science and humanistic assignments, which are easier to complete, skip classes when necessary, and save the limited time they have to study for the science courses. As clerkship is much less structured than pre-clerkship, students seek opportunities for feedback and learning experiences that are geared toward their interests. Students also adjust their expectations for learning based on the clinical rotation that they are on, and its learning environment and acceptance of clerkship students. They manage to fit in the environment and culture as they know getting a good evaluation depends on being liked by the team. Students have knowledge of their situations and how to behave under different circumstances, though they might not explicitly articulate that.

The social knowledge that medical students skillfully apply to behave socially and construct routines is more often practical consciousness than discursive consciousness. When social knowledge in medicine is transmitted and accepted by students, their actions become habitual and taken-for-granted, which contributes to routinization. The routine aspect of learning and practice also allows students to gradually claim identities as they seek to perform and attempt to manage others’ impressions of themselves (Monrouxe, 2010). Tacit knowledge or practical consciousness is fundamental to structuration theory and the process of structuration. The structural features of an institution do not work “behind the back” (Giddens, 1979, p. 7) of individuals; on the contrary, the objective societal phenomena rely heavily on the knowledgeable actions of individuals. Practical consciousness provides knowledge of how to go about daily life according to the community’s norms. Practical consciousness enables medical students to interpret, understand, and meet the expectations that medical school has for them. Medical students’ reflexive monitoring of their ‘conduct, accountability, and behaviour’ not only draws upon but also reproduces “forms of tacit and discursively available knowledge” in medical education and medical practice (Giddens, 1979, p. 128). The routines, institutional practices, and taken-for-granted knowledge, formed through the daily activities and interactions, contribute to structuration in medical education and medical practice.

Tacit knowledge is not only functional in medical education, but it should also be understood from a critical approach. While tacit knowledge is an important channel of students’ learning of professionalism and PIF, the power relations are also made clear by tacit knowledge. The power relations in medical school are significant in that role models are often also evaluators. Learning and defining competency are comprised of not only students’ isolated behaviours (Duncan & Weiss, 1979) but also interactions between individuals who come from groups with different status and have different priorities. These two processes are extra-individual and take place in a community of practice that has a strict hierarchical structure, which means that power relations are implied in learning in medical education (Farnsworth et al, 2016). Though situated in post-secondary settings, medical education is a process of socialization because of its explicit normative emphasis and its power structure. Because ruling relations are connected to and constructed by objectified knowledge, medical students have the lowest status and highest dependence in medical practice. Combined with their high motivation to assume professional roles, and commitment and need to be successful, medical students lend considerable power and influence to preceptors as socializers (Shuval, 1975). The unintended consequences of having strict policies, procedures, and rules often fall on medical students who are regulated by them.
Numerous examples demonstrate the power relations in medical school and their impact on students’ learning. The culture of fear, resulting from the CoM’s professionalism policy, students’ conformity with rules and expectations, even those that they do not agree with, and especially their hesitancy to speak up when gaps are identified between what they are taught and what they observe are some of the examples. What is more important, however, is perhaps how power relations can adversely prevent meaningful changes from happening in medical practice and health care delivery. The previous section on tacit knowledge has illustrated significant gaps between the three types of curricula on the learning of professionalism and professional roles. This is made worse when the medical profession relies on the incoming generations to make meaningful changes to the practice of medicine in realizing the ideals such as interprofessional practice, patient- and family-centered care, equity in access to care, and physicians’ work-life balance. Students are not only not learning the ‘hows’ of achieving these goals, but also are forced to work in an environment that does not always value these visions and reproduces some of the behaviours that are in themselves in direct contrast to these visions.

The findings from this study reaffirm the hierarchy of discourses within the medical profession, in which the discourses of objective science and competency occupy the authoritative position while the discourses of the social components of care and caring are marginalized (MacLeod, 2010). The ranking, to a great extent, establishes in medical education what is considered appropriate in knowledge and learning. It is well-articulated in the formal curriculum that competency and caring both contribute to the practice of medicine. However, the central concern of competency, which focuses on objective and evidence-based science, continues to separate biomedical concerns from social concerns, and competency from caring (MacLeod, 2010). The gaps between the ideals listed in documents that have mostly theoretical presence and the more informal normative rules that practically govern actions continue to exert influence on students. The discussion on the importance of professional identity in medicine and medical training adds a dynamic component to the current construction of a competency-based medical education model, which “seeks to educate students towards specific standards as they are articulated in core competencies” (Frost & Regehr, 2012).

The argument to include the discourse of identity is not to replace the discourse of competency as medical students need to continue to build on their knowledge and skills to apply safely and adequately the ever-growing scientific advancement; rather, identity is an important complement to the discourse of competency. At the same time, it needs to be acknowledged that some of the physician roles that contribute to the intended professional identity cannot be taught the same way as competency in scientific knowledge and skills. The practice of the different physician roles and the learning of various aspects of medical professionalism that support PIF are best facilitated through experiential learning in communities, positive role modelling, patient encounter, and informal learning with preceptors.

As the medical curriculum continues to be revised to meet the changing expectations of patients and society, medical students in different cohorts and generations could have different understandings of medicine based on their learning experiences. This allows them to bring new perspectives when they start to participate in the community of medical practice. When medical
students start clerkship, they already have an understanding of patient-centered care and interprofessional practice. They know the rationale behind these goals and have the abstract knowledge of the guiding principles to facilitate these practices, which might be new knowledge to some of their preceptors who were trained when these aspects of knowledge were not a priority. However, the interpretation of structure is reflected in both the conditions and consequences of human actions. Therefore, medical students, in their attempt to manage risks with attending medical school, fit into the environment, and earn the right to full participation, may not have the aspiration or tools to advocate for change or make change happen in practice.

As both the identification and practices are local, medical students, who have their own local forms of engagement with and knowledge of competency, do not simply implement best practices (Farnsworth et al., 2016). Medical students contribute to the structuration of the medical practice through internalizing the practices that are asked of them in their immediate environment and active participation. The medical education system is tasked with training a generation of physicians that could meet the health needs of the future. However, because students are trained in the community of medical practice, the resistance to change for a health care system that meets society’s expectations indeed comes from inside the medical education system. It is easier to come up with best practices and blueprints but much more difficult to facilitate them into local practice, which make it essential to recognize the complexities within the negotiation of identity and practice, for both students and faculty. Medical schools cannot rely on the incoming medical students and physicians to improve the practice of medicine without considering the impact of their learning environment, which is the environment in which the current physicians work.

The contexts and forms of medical practice are rapidly changing and are increasingly characterized by teamwork and collaborative practice, which some argue makes “interprofessional” an identity in its own right (Thistlethwaite et al., 2016). The commercial restructuring of medical care and visible evidence of self-interest of some individual physicians, medical programs, and medical institutions have made the medical profession fallen dramatically in public trust (Mechanic, 1996). Repeated evidence of competence, responsibility, caring, and commitment to responsive and high-quality health care are needed for building and maintaining public trust in medicine (Mechanic, 1996). To create meaningful change and facilitate medical students’ development of a robust professional identity, it is crucial to understand and appreciate the impact of the informal curriculum and the daily interactions that happen in the teaching and learning community. As Suchman et al. (2004) argue, standardized prescriptive interventions, measurements, and benchmarking will not work for changing patterns of interaction. Instead, they adopted a nonlinear perspective and envisioned their work as introducing constructive disturbances in existing patterns of interaction (Suchman et al. 2004). By introducing appreciative storytelling and focusing on relationships instead of individuals, they see evidence of a shift in institutional identity that raises hope and prompts behaviours that are consistent with values identified in the formal curriculum (Suchman et al. 2004).

Reflective practice, which depends on breaking the silence for faculty and students, and institutional values and structures that facilitate critical reflection, is a promising strategy for PIF
Reflective practice in medical education allows students to turn an encounter into a potential learning opportunity and reflect on interactions as they are taking place (Atkin & Murphy, 1995). It goes beyond the knowledge and skills aspects to include the affective component of a situation. When reflective practice is facilitated by medical school to encourage informal learning, the thought and decision-making processes of ethical and moral judgments that guide physicians' behaviours are made explicit (Kenny et al. 2003). In doing so, the gaps between different types of curricula could be narrowed and faculty are teaching what they intend to teach and students are learning what faculty are teaching.

In contrast to the construction of formal learning communities in modules or programs in medical school, community should be recognized as an emerging and continuous process marked by mutual engagement. During the process, participants ‘think together’ about and work through real-life situations and problems that impact their daily work and experiences, which “give life to communities of practice” (Pyrko, 2017, p. 403). Community of practice with its focus on mutually engaged social learning processes not only is an essential channel of knowledge sharing, but also contributes to knowledge development and thriving practice under challenging circumstances (Kuhn & Jackson, 2008). When the medical profession is aiming to provide a more efficient, patient-centered, and collaborative health care, it is not enough for learners to simply acquire knowledge; rather, knowledge needs to be constructed as people learn together and learn from each other.

The goal of IE is to learn from the local actualities and use that knowledge to reorganize and transform social relations (Smith, 2005). The findings from this study reaffirm that power relations in medical school and medical practice significantly impact students’ learning experiences with professionalism and professional identity. Participants in this study have rarely reported instances of student mistreatment (e.g., being ignored and humiliated) as some of the literature on hidden curriculum has revealed (Barrett & Scott, 2015; Chuang et al., 2010). However, the CoM’s institutional practices on teaching, especially on strictly enforcing the professionalism policy, serve a social control function. By internalizing a culture of fear, students are socialized to not cross boundaries but to respect and reproduce hierarchy. This creates distraction in learning for students as they are always concerned about fitting in with a team and getting a good evaluation. It also undermines students’ motivation for change and advocacy as they do not feel like they have the power or authority to know what might work better.

Transforming the social environment of medical schools could create better communities of learning in which medical students are meaningfully treated as colleagues, and are guided and supported in their development of professionalism and PIF. Benbassat (2012) argues that, to promote a nurturing learning environment in medical education, students need to realize that, in many clinical situations, they are not alone in their fears and doubts, which are shared by their preceptors. The challenge is to advance a clinical and learning environment in which errors and uncertainties are acknowledged rather than denied and learners are supported and trusted instead of judged (Benbassat, 2012). It is also important to recognize that, though students are trained in the community of medical practice, the goal of medical education is transformative learning and the focus should be put on student learning instead of faculty teaching. Therefore,
medical schools should listen to and learn from students’ learning experiences, facilitate learning mechanisms that are crucial to their learning, and abandon those that are administratively convenient but are not effective or could have counterproductive impact.

At the same time, it is also important to recognize that medical students are not just passive receivers of objective knowledge that is stored in the medical education system or simply follow the linear pathway of professionalism and professional roles drawn for them. They are active creators of their own understanding of the medical profession and build their own pathways of how they want to practice medicine, based on their interests and previous experiences. Understanding the formation of professional identity as individuals are situated within a community of practice represents a crucial social process linking structures with individuals. Though external effort is made to shape, dictate, or mandate practice, it can only reflect the meanings arrived at by those who actively engage in it. Rules themselves inhabit time and space and are fairly consistent; however, the ability to follow rules and meet expectations resides in individuals. It may seem medical students comply with external mandates, but they produce a practice that reflects their own engagement with the situation. Practice cannot be subsumed by texts, a policy, or an institution. The structuring elements continue to be present; however, practice is not simply their output or implementation but participants’ response to them, based on their active negotiation of meaning and identity.

While the community and broader structures provide expected roles, individuals actively create social behaviours to test the boundaries and negotiate the roles that they want to play. They not only adhere to and adjust to the expectations that medical school has for them, but also add new perspectives to the community. Medical students’ own motivations and their expectations for themselves allow them to bring some uniqueness to the community. When asked to describe their experiences, medical students not only identified the more common learning mechanisms in medical school but also explained the experiences and perspectives that were unique to them. Within boundaries, students find opportunities to actively distinguish themselves from others, whether it is on their performance on professionalism or understanding of the medical profession. They aim to build an identity of medical student that is unique and true to their values and interests, for example, the one that volunteers a lot, the one that values patient interaction, or the one that does a lot of self-reflection. When building an identity, students try to prove that they not only belong to the medical profession but also have something unique to offer.

Two discourses that are revealed in this study and at play in PIF in medical education – standardization and diversity – are not just heterogeneous but often in tension (Frost & Regehr, 2012). The discourse of diversity focuses on individuality and a plurality of possibilities while standardization emphasizes fundamental sameness and a single uniform way of being a physician (Frost & Regehr, 2012). On professionalism and professional identity in medical education, standardization is translated into professionalism standards and a single pathway of professional roles. Students, however, rely on and draw on the discourses of both standardization and diversity when constructing their professional identities. In this sense, the formation of professional identities for medical students is both socially constructed and deeply personal. Depending on who they are and their life experiences before medicine, medical students find
their own approaches to navigate, negotiate, and reconcile the contradictions between standardization and diversity, and construct their professional identities through these experiences.

Though efforts have been made to diversify the physician workforce, most of them focus on increasing the compositional diversity of students, which is often viewed as parallel to the core institutional mission. The theories and instructional methods on PIF have traditionally aimed to shape students' attitudes so that they conform to a uniform notion of professionalism (Stetson & Dhaliwal, 2020). In PIF, research focus is slowly changing from a more functional approach to a more critical approach, in which the disadvantageous position that minority medical students face is being closely examined and suggestions on how to support them are proposed. Research on PIF in recent years has started to examine diversity, inclusion/exclusion, the experiences of ethnically/racially minoritized physicians and medical trainees (Wyatt et al., 2021; Wyatt et al., 2021; Wyatt et al., 2020). For example, in a study that investigates the PIF of Black/African American medical students, residents, and physicians, participants described their professional identity in relation to serving their racial/ethnic community (Wyatt et al., 2021). They emphasized using that professional identity to challenge the broader social, historical, and cultural mistreatment of Black Americans, the findings of which remain absent in the dominant research on PIF (Wyatt et al., 2021).

This study has revealed the specialty-defined professional identity and the individuality that students pursue in their enculturation to the profession, the latter of which contributes to students' motivation and desire to learn more and do better. Strategies are needed to better capture and leverage differences in students' and physicians' backgrounds and perspectives to develop a culture of inclusion both within medical schools and the medical profession to better serve the needs of the public (Nivet, 2011). Though I have discussed some implications of the findings from this study in each of the above three sections, the next section highlights some key factors to consider in facilitating the teaching and learning of professionalism and professional identity in medical education moving forward.

7.5 Moving forward – the place of professionalism and professional identity in medical education

The findings from this study show that it is much easier to argue the importance of professionalism and professional identity in medical education than to facilitate transformative learning on these two subjects. Despite the fact that the phenomena of professionalism and professional identity have come to be analyzed in more complex ways (Hafferty & Levinson, 2008), more evidence-based initiatives and strategies are needed to support faculty teaching and student learning. To ensure that physicians are broadly educated, practice professionalism, and develop an appropriate professional identity, a medical curriculum that promotes a sociological consciousness, interdisciplinary thinking, and understanding of the economic/political dimensions of health care, needs to be developed (Wear & Castellani, 2000).
As professionalism spans a much broader scope, many of the topics that are covered in the course *Medicine and Society* could be rigorously exposed to and explored by students through a professionalism lens. In the medical education literature, there are some attempts to be more inclusive of the dimensions of professionalism in medicine. For example, Stark and Fins (2014), in discussing pervasive thinking errors in decision-making in medicine, have argued that “self-reflective and metacognitive refinement of critical thinking should not be construed as optional but...a codified tenet of professionalism, and by extension, a moral and professional duty” (p. 386). Rothman (2000) argues that medicine should, in its organized capacity, encourage and protect whistle-blowers to identify and publicize problems and areas for improvement instead of depending completely on outsiders and this should be one aspect of medical professionalism. It is also argued that the Choosing Wisely campaign is at its core about advancing medical professionalism and about physician’s value of providing the best and most efficient care for patients through avoiding unnecessary or harmful interventions (Baron & Wolfson, 2015).

When students’ observations or interactions in clinical environments contradict their formal learning, without a forum to discuss the discrepancies, students tend to seek clues from the environments that they inhabit and conform to the institution’s practices (Monrouxe, Rees, & Hu, 2011). The double standards, tensions, and mixed messages can lead to students’ feelings of frustration and resentment, and disinterest toward professionalism education (Sternszus, 2016). Therefore, medical schools need to provide opportunities for students to engage in active sense-making activities (Monrouxe, Rees, & Hu, 2011). These activities should be frequent, ongoing, and with support from peers and clinical educators to encourage an embodied, nuanced, and sophisticated understanding of professionalism (Monrouxe, Rees, & Hu, 2011). Teaching on professionalism should also take advantage of students’ clinical encounters, which are powerful opportunities for students to apply the principles of professionalism and engage in meaningful discussion on professionalism (Francis, 2004).

PIF is the process during which individuals link their motivations and competencies to a professional role. This means that identity needs to have more presence in the medical education curriculum to ensure that the identity element is consistently considered in parallel to competencies. Since the process involves both professional growth and personal development (Holden, 2015), for professional identity, medical schools should perhaps aim for the outcome of transformation instead of simply formation (Wald, 2015). PIF is a complex journey, which not only involves common learning mechanisms such as role modelling and patient encounter but also is deeply personal and depends on students’ own life experiences, motivations, and interests. Therefore it cannot be taught through a linear and simplistic approach. Medical students should also not be left alone to navigate the complexity of being medical students and working in the medical community. Defining the goal of medical education as training medical students to “think, act, and feel” (Merton et al., 1957) like physicians is perhaps no longer adequate. Medical school and educators must act on their role of facilitators to ensure that students’ unique backgrounds and motivation for pursuing medicine can be acknowledged and nurtured. This way, medical students have better learning experiences and the diversity in medical students and future physicians could better serve the public. Since role modelling and informal teaching are inherently significant in medical education, faculty development should continue to be a priority.
for medical schools so that faculty have the awareness and tools to facilitate students’ continuous development (Dennis & Davies, 2020; Stefan et al., 2019).

The concepts of both professionalism and PIF in medical education are not new; neither are the calls for the medical profession to recommit to medical professionalism and support students’ PIF (Forouzadeh et al., 2018); however, students’ learning experiences in medical schools remain similar (Chandran et al., 2019). Therefore, research needs to further identify the source of resistance to change. Medical schools need to conduct critical assessment of the learning environment and understand students’ learning experiences, the knowledge of which could support initiatives and learning mechanisms that are beneficial to students’ learning (Cooke, 2010). Theoretical approaches and methodology that could support our understanding of the interplay between structure and agency in medical school and medical education need to be intentionally explored and utilized. For example, preliminary findings have found the emergence of informal student networks, which suggests the potential to view medical schools as socially networked learning environments and use social network analysis to map the formal and informal mechanisms of student learning (Hafferty, & Pawlina, 2013).

All these changes may only be possible when the medical community is willing to see their work differently. It may be worthwhile to problematize the contexts within which physicians work and students learn, drop the assumptions of how things always work and should work in certain ways, and meaningfully engage with different stakeholders (including students) in difficult and candid conversations. It could also be beneficial to revisit the fundamental core values of physicians, examine the conflict between self-interest and the better good, and acknowledge that there is more happening than the perfect image of physicians that they wish to present. Initiatives that bring forward the socially constructed nature of professionalism and professional identity should be developed to facilitate the conversations between the medical community and the public. For example, medical school could invite the public (e.g., patients or families or advocates) to be some of the members that hand out white coats to medical students at the white coat ceremony. It perhaps could be one of the first steps to acknowledge that it is not just physicians welcoming medical students to join the medical community; it is also the public entrusting medical students to help improve health and well-being of the population.

7.6 Contributions and limitations

In applying sociological theories and methodology to understand students’ learning of professionalism and PIF in medical education, and bridging together two fields of literature and research, this study has made some unique contributions. First, the study has introduced empirical research which applies two sociological theories – structuration theory and community of practice theory – to better understand the dynamics of learning professionalism and PIF in medical education. While both theories understand learning as social practice and acknowledge the importance of tacit knowledge in learning and the knowlegdeability of participants, each focuses on specific aspects and serves a specific purpose in understanding the complexity of medical training.
In the study, medical students’ learning experience is understood in relation to the communities in which they learn and work as they constitute each other (Farnsworth, Kleanthous, & Wenger-Trayner, 2016). Understanding the internalization of professionalism and PIF from the approach of community of practice theory gives an account of medical students’ legitimate peripheral participation in the socially situated learning, which is also an experience of meaning making. The concept of community of practice emphasizes the interactive nature of medical education, especially in clerkship. The ever-growing literature of its application to supporting knowledge sharing and production has potential for medical education in further facilitating medical students’ learning and development.

Structuration theory brings in a more critical stance to the analysis by providing an explanation of why change in institutional culture and practice is difficult and identifying the internal resistance to change. The hierarchy of discourses in medical training, which prioritizes competency or expert role and devalues caring or other physician roles, continues to exert significant influence on medical schools’ teaching practices. Because of this, changes made to the formal curriculum on professionalism and professional identity have little impact on medical students’ learning experiences. The knowledgeability of participants, which they gain from the informal curriculum, allows them to understand and follow guidelines and rules, but only those that are currently practiced in the community and have more immediate concerns for them. These two theoretical frameworks complement each other in understanding the processes and consequences of medical education.

Second, in contrast to most of the literature in medical education that emphasizes the importance of the informal curriculum or hidden curriculum without providing empirical data, this study utilizes the methodology of IE and collects first-hand data of students’ learning experiences. In adding faculty’s perspective to the discussion, this study reveals how the work of both sets of participants – students’ learning and faculty’s teaching – is constrained by institutional practices. The methodology of IE is crucial for this study as it not only documents individual experiences, but also makes visible social relations and identifies institutional practices that underpin individual experiences. This study takes into consideration the power of texts, the socially constructed nature of knowledge in institutions, and the influence of the social conditions of learning. In doing so, it provides a detailed and systematic account of medical students’ learning experiences of professionalism and professional identity in one medical school. Overall, this study reaffirms the longstanding relevance of the application of sociological theories and methodologies to understanding medical education, introducing unique insights about tensions within medical training and professional development.

Lastly, this study has made some contribution to a practical issue in medical education literature, which is the operationalization of the concept of curriculum in empirical research. By utilizing different methods of data collection, including document analysis, participant observation, and in-depth interviews with medical students and faculty, and building on Hafferty’s (1998, 2000, 2009) contribution to curriculum analysis in medical education, this study helps to further clarify the concept of curriculum in medical education. Researchers should consider not only where the curriculum happens but also the learned knowledge, which reflects the gap between what is
delivered and what is received, when providing definitions of and distinguishing between the different types of curricula. More importantly, further research should continue to take into consideration the importance of students’ lived experience, which highlights the idea that what students learn is not hidden from them but the medical educators.

There are, however, a few limitations to this study. First, while this study only focuses on the undergraduate medical education, learning of professionalism and PIF are developmental processes that extend beyond the four-year MD program. Residency, in which medical trainees take on more responsibilities, is likely a more important time for trainees’ PIF but is beyond the scope of this study (Chew et al., 2021; Sawatsky et al., 2020). Second, my decision to not gather data through participant observation in clerkship was partially due to the context of clerkship, in which training involves real patients, and the complexity involved with ethics review, which requires CoM’s institutional support. It was already difficult to gain access to interviewing students and faculty and conducting participant observation in pre-clerkship courses that are relevant to professionalism and professional identity. I also made the decision because of the limited time and resources that constrain the scope of a PhD study. The interviews with participants, who were overwhelmingly candid, are considerably in-depth as they shared many examples and experiences in relation to their perspectives and arguments. This, to a large extent, mediates the absence of participant observation data of clerkship. However, future work that utilizes observational and ethnographic data could reveal forms of tacit knowledge in clerkship, especially in students’ interactions with preceptors and patients, and provide a broader picture of students’ learning experiences.

Lastly, this study has some limitations with regards to research samples and its potential for generalization. Because the main goal of qualitative study is to describe and understand experiences and processes, it does not have the large dataset to support generalization. Furthermore, IE emphasizes social contexts with a goal to understand social conditions of practice through participants’ lived experiences. Participants have overwhelmingly indicated the phenomena and lived experiences described in this study were not uncommon across Canadian medical schools. However, this study can only reveal the CoM’s unique institutional practices on teaching and learning of professionalism and professional identity, and more empirical research is needed to verify a universal pattern.

Even though the numbers of medical students and faculty who participated in this study are not small for this scale of a qualitative study, I had encountered difficulty with recruiting participants from specific racial groups. Despite my efforts to capture and present the diversity of participants’ experiences in the results section, I was not able to approach the data from a racial perspective. It might be because female medical students have been representing more than half of the incoming medical students at the CoM, gender did not come across as a significant factor that impacts students’ learning experiences in medical school in the discussion. Future research could intentionally and explicitly explore the correlation between gender or race, and PIF in medical education amid changes in medical practice. It is also understandable that students and faculty who participated in this study are those who are interested in or concerned about the topics of professionalism and professional identity in medical education. Although participants’ reflection
shed some light on the attitudes of other people at the CoM, I was not able to speak directly with those who might seldom reflect on these two topics.

7.7 Conclusions

Most of what the medical profession puts on paper as noble and worthy of aspiration and imitation is consistent with sociological principles of what medical professionalism is (Hafferty & Castellani, 2011), which specifically highlights the socially constructed nature of the concept. However, the practice of medical schools’ teaching on professionalism is not about the noble and worthy. The CoM’s focus on student professionalism and professionalism in professionals serves mostly as a social control function in regulating students’ study habits and social behaviours. This is not effective in transformative learning or supporting students to develop knowledge, skills or inspiration to perform medical professionalism. The CoM’s institutional practice contributes to students’ cynical attitude towards professionalism issues and adversely steers students away from actively engaging in conversations and reflections on professionalism.

Medical students learn professionalism and develop professional identities in the communities, from pre-clerkship in the community of medical students to clerkship in the community of medical practice. Clerkship is a more significant stage of learning of professionalism and PIF as students’ immersion in the community of medical practice provides not only explicit but also tacit knowledge to master the practice of medicine. Through legitimate peripheral participation in a situated learning environment, students develop a more realistic understanding of medical professionalism and physician roles, and develop a specialty-defined professional identity. While there are common learning mechanisms in medical education that support PIF, the process is also deeply personal, which requires mentorship and an institutional culture that celebrates inclusion and diversity.

Many changes have been made to the formal curriculum and, to some extent, the informal curriculum in medical education to support students’ learning of professionalism and development of a professional identity that performs more roles than simply the medical expert. However, the gap between what students are taught in classroom and what they observe and are taught in practice is still significant. Medical students continue to develop and negotiate their professional identities in the context of competing discourses where the other physician roles often lose the battle to the role of medical expert. The medical profession is advocating for changes in medical practice to better serve the public and provide health care that is culturally sensitive, interprofessional, and patient- and family-centered. Amid these changes, there is great potential in understanding medical education as a social practice and building better communities of learning to facilitate medical students’ personal and professional growth.
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Appendix A CoM Ethics and Professionalism Document

Ethics and Professionalism

The College of Medicine statement on professionalism (2005)

We, as teachers, learners and educational support personnel of the College of Medicine, University of Saskatchewan have a responsibility to ourselves as individuals, to each other, and to patients and society as a whole, to understand and exhibit the highest standards of personal, interpersonal, and public professionalism.

1. As individuals, we commit to demonstrating the personal characteristics necessary for moral function within the medical profession and the university community, and as representatives of these occupations within society as a whole. Such characteristics will include but are not limited to humility, respect for others, and self-care.
2. As caregivers, colleagues and coworkers, we will demonstrate professional interpersonal behaviour in all settings, guided by the values of integrity, accountability, and responsibility.
3. As medical professionals, learners, and educational support personnel interacting in the public domain, we will strive to fulfill all reasonable health-related societal expectations, demonstrating at all times compassion, reliability, honesty, respect, and an appropriate level of competence. We will seek to promote the public good and understand the principles of good stewardship. We will adhere to the Codes of Ethics of our professions and occupations.

We consider these to be important standards describing the expectations we have of ourselves and of each other, and will treat any significant divergence as a serious threat to the mission and values of the College of Medicine.

The College of Medicine’s Guiding Principles of Professionalism

Respect for others

Professionals demonstrate consideration and respect for others including patients, their families and support persons, colleagues, classmates, teachers, other professionals and the public.

- We don’t allow our conduct to negatively impact others’ learning or clinical activities
- We don’t discriminate against others on the basis of such grounds as age, race, colour, ancestry, place of origin, ethnicity, political beliefs, religion, marital status, family status, physical or mental disability, sex, sexual orientation or gender identity
- We demonstrate respect for the dignity and rights of patients and their families or support persons, taking into account their diversities, both in their presence and in discussion with other members of the health care team
- We accept and promote patient autonomy in decision-making, and when the patient lacks capacity, we consult with and appropriately take direction from surrogate decision-makers
• We respect the personal boundaries of others and refrain from making unwanted or inappropriate romantic or sexual overtures towards others
• We communicate respectfully with others both verbally and in writing
• We respect the privacy and confidentiality of those to whom we owe that duty

Honesty and integrity

Professionals demonstrate adherence to the highest standards of personal, professional and academic honesty and integrity.

• We communicate truthfully with others verbally and in writing
• We don’t falsify documents or records
• We acknowledge and manage conflicts of interest appropriately, avoiding conflicts of interest, real or apparent, whenever there is potential detriment to others
• We admit and disclose errors
• We make accurate records of conversations, histories, physical findings and other information pertinent to patient care
• We don’t engage in plagiarism, nor do we give or receive assistance during an examination or in completion of an assignment unless such is expressly permitted
• We conduct research in an ethical manner, analyzing and reporting results accurately and fairly
• We credit the ideas and work of others appropriately and fairly

Compassion and empathy

Professionals demonstrate compassion and empathy for those in distress and especially for patients, their families and support persons.

• We demonstrate effective listening
• We are aware of and respectful of others' differences and respond appropriately to their needs
• We show compassion and provide support for patients, their families and support persons dealing with illness and/or dying and death

Duty and responsibility

Professionals acknowledge their duties to patients, their profession and society and accept the responsibilities that flow from these duties.

• We attend to patients' best interests and well—being as the first priority
• We work cooperatively with others for the benefit of our patients and contribute to a healthy working environment for all
• We make equitable and prudent use of health care resources under our control
• We are responsible to society for matters relating to public health
• We recognize and adhere appropriately to policies, codes, guidelines and laws that govern us and our work
• We participate in the process of self—regulation of the profession
• We address misconduct, incompetence or behaviours that put patients or others at risk
• We share resources and expertise, and assume responsibility for our portion of a fairly distributed workload; where issues of fair distribution arise, we act most immediately in the patient’s best interests, and seek to resolve issues of fairness through appropriate channels
• We respond in an appropriate, non-judgmental and non-demeaning manner when our expertise is sought
• We don’t take advantage of colleagues, learners, patients, their families or support persons or others for emotional, financial, sexual or other personal purposes, and we conduct research and educational activities with these groups only with appropriate informed consent
• We fulfill commitments, meet deadlines and are punctual particularly where these behaviours have significant impact on others; where we’re unable to do so, we communicate appropriately to mitigate any negative impacts
• We engage in lifelong learning, maintain clinical competence and strive for continuous quality improvement
• We take appropriate and necessary responsibility for our personal health and well-being
• We recognize our own limitations and seek assistance appropriately
• We display dress, behaviour and demeanor in the educational and healthcare setting in keeping with appropriate pedagogical, clinical or safety standards

Used with Permission Dalhousie University Faculty of Medicine “Dalhousie Medical School Professionalism Committee Professionalism Policy”.

The complete College of Medicine Procedures for Concerns with Medical Student Professional Behaviour and related documents can be found at: **

**Canadian Medical Association Code of Ethics**
(Update 2004; reviewed March 2015)

This Code has been prepared by the Canadian Medical Association as an ethical guide for Canadian physicians, including residents, and medical students. Its focus is the core activities of medicine – such as health promotion, advocacy, disease prevention, diagnosis, treatment, rehabilitation, palliation, education and research. It is based on the fundamental principles and values of medical ethics, especially compassion, beneficence, non-maleficence, respect for persons, justice and accountability. The Code, together with CMA policies on specific topics, constitutes a compilation of guidelines that can provide a common ethical framework for Canadian physicians.

Physicians should be aware of the legal and regulatory requirements that govern medical practice in their jurisdictions.
Physicians may experience tension between different ethical principles, between ethical and legal or regulatory requirements, or between their own ethical convictions and the demands of other parties. Training in ethical analysis and decision-making during undergraduate, postgraduate and continuing medical education is recommended for physicians to develop their knowledge, skills and attitudes needed to deal with these conflicts. Consultation with colleagues, regulatory authorities, ethicists, ethics committees or others who have relevant expertise is also recommended.

**Fundamental Responsibilities**

1. Consider first the well-being of the patient.
2. Practise the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect.
3. Provide for appropriate care for your patient, even when cure is no longer possible, including physical comfort and spiritual and psychosocial support.
5. Practise the art and science of medicine competently, with integrity and without impairment.
6. Engage in lifelong learning to maintain and improve your professional knowledge, skills and attitudes.
7. Resist any influence or interference that could undermine your professional integrity.
8. Contribute to the development of the medical profession, whether through clinical practice, research, teaching, administration or advocating on behalf of the profession or the public.
9. Refuse to participate in or support practices that violate basic human rights.
10. Promote and maintain your own health and well-being.

**Responsibilities to the Patient**

**General Responsibilities**

11. Recognize and disclose conflicts of interest that arise in the course of your professional duties and activities, and resolve them in the best interest of patients.
12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants.
13. Do not exploit patients for personal advantage.
14. Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient.
15. Recognize your limitations and, when indicated, recommend or seek additional opinions and services.
16. In determining professional fees to patients for non-insured services, consider both the nature of the service provided and the ability of the patient to pay, and be prepared to discuss the fee with the patient.

**Initiating and Dissolving a Patient-Physician Relationship**

17. In providing medical service, do not discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status. This does not abrogate the physician’s right to refuse to accept a patient for legitimate reasons.
18. Provide whatever appropriate assistance you can to any person with an urgent need for medical care.
19. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given reasonable notice that you intend to terminate the relationship.
20. Limit treatment of yourself or members of your immediate family to minor or emergency services and only when another physician is not readily available; there should be no fee for such treatment.

*Communication, Decision Making and Consent*

21. Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.
22. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood.
23. Recommend only those diagnostic and therapeutic services that you consider to be beneficial to your patient or to others. If a service is recommended for the benefit of others, as for example in matters of public health, inform your patient of this fact and proceed only with explicit informed consent or where required by law.
24. Respect the right of a competent patient to accept or reject any medical care recommended.
25. Recognize the need to balance the developing competency of minors and the role of families in medical decision-making. Respect the autonomy of those minors who are authorized to consent to treatment.
26. Respect your patient’s reasonable request for a second opinion from a physician of the patient’s choice.
27. Ascertain wherever possible and recognize your patient’s wishes about the initiation, continuation or cessation of life-sustaining treatment.
28. Respect the intentions of an incompetent patient as they were expressed (e.g., through a valid advance directive or proxy designation) before the patient became incompetent.
29. When the intentions of an incompetent patient are unknown and when no formal mechanism for making treatment decisions is in place, render such treatment as you believe to be in accordance with the patient’s values or, if these are unknown, the patient’s best interests.
30. Be considerate of the patient’s family and significant others and cooperate with them in the patient’s interest.

*Privacy and Confidentiality*

31. Protect the personal health information of your patients.
32. Provide information reasonable in the circumstances to patients about the reasons for the collection, use and disclosure of their personal health information.
33. Be aware of your patient’s rights with respect to the collection, use, disclosure and access to their personal health information; ensure that such information is recorded accurately.
34. Avoid public discussions or comments about patients that could reasonably be seen as revealing confidential or identifying information.
35. Disclose your patients’ personal health information to third parties only with their consent, or as provided for by law, such as when the maintenance of confidentiality would result in a significant risk of substantial harm to others or, in the case of incompetent patients, to the patients themselves. In such cases take all reasonable steps to inform the patients that the usual requirements for confidentiality will be breached.
36. When acting on behalf of a third party, take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to the third party.
37. Upon a patient’s request, provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.

Research
38. Ensure that any research in which you participate is evaluated both scientifically and ethically and is approved by a research ethics board that meets current standards of practice.
39. Inform the potential research subject, or proxy, about the purpose of the study, its source of funding, the nature and relative probability of harms and benefits, and the nature of your participation including any compensation.
40. Before proceeding with the study, obtain the informed consent of the subject, or proxy, and advise prospective subjects that they have the right to decline or withdraw from the study at any time, without prejudice to their ongoing care.

Responsibilities to Society
41. Recognize that community, society and the environment are important factors in the health of individual patients.
42. Recognize affecting the health or well-being of the community and the need for testimony at judicial proceedings.
43. Recognize the responsibility of physicians to promote equitable access to health care resources.
44. Use health care resources prudently.
45. Recognize a responsibility to give generally held opinions of the profession when interpreting scientific knowledge to the public; when presenting an opinion that is contrary to the generally held opinion of the profession, so indicate.

Responsibilities to the Profession
46. Recognize that the self-regulation of the profession is a privilege and that each physician has a continuing responsibility to merit this privilege and to support its institutions.
47. Be willing to teach and learn from medical students, residents, other colleagues and other health professionals.
48. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.
49. Be willing to participate in peer review of other physicians and to undergo review by your peers. Enter into associations, contracts and agreements only if you can maintain your professional integrity and safeguard the interests of your patients.
50. Avoid promoting, as a member of the medical profession, any service (except your own) or product for personal gain.
51. Do not keep secret from colleagues the diagnostic or therapeutic agents and procedures that you employ.
52. Collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services. Treat your colleagues with dignity and as persons worthy of respect.

Responsibilities to Oneself
53. Seek help from colleagues and appropriately qualified professionals for personal problems that might adversely affect your service to patients, society or the profession.
54. Protect and enhance your own health and well-being by identifying those stress factors in your professional and personal lives that can be managed by developing and practising appropriate coping strategies.

**Student Oath of Commitment** (As declared by students during their White Coat Ceremony at the beginning of Year 1)

_As I begin my training as a physician at the University of Saskatchewan, College of Medicine I pledge the following:_

I promise to earn the trust and respect of my teachers and to return them in kind, for only through mutual trust and respect can we learn the skills required of a physician.

I will adhere to the standards of professionalism as specified by the college, such that my conduct upholds and reflects the high calling of my profession.

I will accept responsibility for those medical duties that I feel prepared for; I will hold back when I am not prepared; and I will seek the experience that I need to prepare myself.

I will strive to preserve the dignity, the humanity and the privacy of all my patients, and through my openness and kindness I will seek to earn their trust in turn.

I will treat my patients and my colleagues as my fellow beings and never discriminate against them for their differences; and I will ask that they do the same for me.

I will value the knowledge, and the wisdom of the physicians who have preceded me; I will add to this legacy what I am able, and I will pass it on to those who come after me.

As my skills and my knowledge grow so too will my awareness of my limitations and my errors; I will strive to recognize and understand my weaknesses;

And I promise never to put an end to my studying and learning that I might improve myself every day of my practice, in all the years to come.

(Modified from the University of Kansas School of Medicine Oath of Commitment.)
Appendix B CMA Code of Ethics and Professionalism

CMA CODE OF ETHICS AND PROFESSIONALISM

The CMA Code of Ethics and Professionalism articulates the ethical and professional commitments and responsibilities of the medical profession. The Code provides standards of ethical practice to guide physicians in fulfilling their obligation to provide the highest standard of care and to foster patient and public trust in physicians and the profession. The Code is founded on and affirms the core values and commitments of the profession and outlines responsibilities related to contemporary medical practice.

In this Code, ethical practice is understood as a process of active inquiry, reflection, and decision-making concerning what a physician’s actions should be and the reasons for these actions. The Code informs ethical decision-making, especially in situations where existing guidelines are insufficient or where values and principles are in tension. The Code is not exhaustive; it is intended to provide standards of ethical practice that can be interpreted and applied in particular situations. The Code and other CMA policies constitute guidelines that provide a common ethical framework for physicians in Canada.

In this Code, medical ethics concerns the virtues, values, and principles that should guide the medical profession, while professionalism is the embodiment or enactment of responsibilities arising from those norms through standards, competencies, and behaviours. Together, the virtues and commitments outlined in the Code are fundamental to the ethical practice of medicine.

Physicians should aspire to uphold the virtues and commitments in the Code, and they are expected to enact the professional responsibilities outlined in it.

Physicians should be aware of the legal and regulatory requirements that govern medical practice in their jurisdictions.

A. VIRTUES EXEMPLIFIED BY THE ETHICAL PHYSICIAN

Trust is the cornerstone of the patient–physician relationship and of medical professionalism. Trust is therefore central to providing the highest standard of care and to the ethical practice of medicine. Physicians enhance trustworthiness in the profession by striving to uphold the following interdependent virtues:

**Compassion**
A compassionate physician recognizes suffering and vulnerability, seeks to understand the unique circumstances of each patient and to alleviate the patient’s suffering, and accompanies the suffering and vulnerable patient.

**Honesty**
An honest physician is forthright, respects the truth, and does their best to seek, preserve, and communicate that truth sensitively and respectfully.

**Humility**
A humble physician acknowledges and is cautious not to overstep the limits of their knowledge and skills or the limits of medicine, seeks advice and support from colleagues in challenging circumstances, and recognizes the patient’s knowledge of their own circumstances.

**Integrity**
A physician who acts with integrity demonstrates consistency in their intentions and actions and acts in a truthful manner in accordance with professional expectations, even in the face of adversity.

**Prudence**
A prudent physician uses clinical and moral reasoning and judgement, considers all relevant knowledge and circumstances, and makes decisions carefully, in good conscience, and with due regard for principles of exemplary medical care.
B. FUNDAMENTAL COMMITMENTS OF THE MEDICAL PROFESSION

Commitment to the well-being of the patient
- Consider first the well-being of the patient; always act to benefit the patient and promote the good of the patient.
- Provide appropriate care and management across the care continuum.
- Take all reasonable steps to prevent or minimize harm to the patient; disclose to the patient if there is a risk of harm or if harm has occurred.
- Recognize the balance of potential benefits and harms associated with any medical act; act to bring about a positive balance of benefits over harms.

Commitment to respect for persons
- Always treat the patient with dignity and respect the equal and intrinsic worth of all persons.
- Always respect the autonomy of the patient.
- Never exploit the patient for personal advantage.
- Never participate in or support practices that violate basic human rights.

Commitment to justice
- Promote the well-being of communities and populations by striving to improve health outcomes and access to care, reduce health inequities and disparities in care, and promote social accountability.

Commitment to professional integrity and competence
- Practise medicine competently, safely, and with integrity; avoid any influence that could undermine your professional integrity.
- Develop and advance your professional knowledge, skills, and competencies through lifelong learning.

Commitment to professional excellence
- Contribute to the development and innovation in medicine through clinical practice, research, teaching, mentorship, leadership, quality improvement, administration, or advocacy on behalf of the profession or the public.
- Participate in establishing and maintaining professional standards and engage in processes that support the institutions involved in the regulation of the profession.
- Cultivate collaborative and respectful relationships with physicians and learners in all areas of medicine and with other colleagues and partners in health care.

Commitment to self-care and peer support
- Value personal health and wellness and strive to model self-care; take steps to optimize meaningful co-existence of professional and personal life.
- Value and promote a training and practice culture that supports and responds effectively to colleagues in need and empowers them to seek help to improve their physical, mental, and social well-being.
- Recognize and act on the understanding that physician health and wellness needs to be addressed at individual and systemic levels, in a model of shared responsibility.

Commitment to inquiry and reflection
- Value and foster individual and collective inquiry and reflection to further medical science and to facilitate ethical decision-making.
- Foster curiosity and exploration to further your personal and professional development and insight; be open to new knowledge, technologies, ways of practising, and learning from others.
C. PROFESSIONAL RESPONSIBILITIES

Physicians and patients

Patient-physician relationship

The patient–physician relationship is at the heart of the practice of medicine. It is a relationship of trust that recognizes the inherent vulnerability of the patient even as the patient is an active participant in their own care. The physician owes a duty of loyalty to protect and further the patient’s best interests and goals of care by using the physician’s expertise, knowledge, and prudent clinical judgment.

In the context of the patient–physician relationship:

1. Accept the patient without discrimination (such as on the basis of age, disability, gender identity or expression, genetic characteristics, language, marital and family status, medical condition, national or ethnic origin, political affiliation, race, religion, sex, sexual orientation, or socioeconomic status). This does not abrogate the right of the physician to refuse to accept a patient for legitimate reasons.

2. Having accepted professional responsibility for the patient, continue to provide services until these services are no longer required or wanted, or until another suitable physician has assumed responsibility for the patient, or until after the patient has been given reasonable notice that you intend to terminate the relationship.

3. Act according to your conscience and respect differences of conscience among your colleagues; however, meet your duty of non-abandonment to the patient by always acknowledging and responding to the patient’s medical concerns and requests whatever your moral commitments may be.

4. Inform the patient when your moral commitments may influence your recommendation concerning provision of, or practice of any medical procedure or intervention as it pertains to the patient’s needs or requests.

5. Communicate information accurately and honestly with the patient in a manner that the patient understands and can apply, and confirm the patient’s understanding.

6. Recommend evidence-informed treatment options; recognize that inappropriate use or overuse of treatments or resources can lead to ineffective, and at times harmful, patient care and seek to avoid or mitigate this.

7. Limit treatment of yourself, your immediate family, or anyone with whom you have a similarly close relationship to minor or emergency interventions and only when another physician is not readily available; there should be no fee for such treatment.

8. Provide whatever appropriate assistance you can to any person who needs emergency medical care.

9. Ensure that any research to which you contribute is evaluated both scientifically and ethically and is approved by a research ethics board that adheres to current standards of practice. When involved in research, obtain the informed consent of the research participant and advise prospective participants that they have the right to decline to participate or withdraw from the study at any time, without negatively affecting their ongoing care.

10. Never participate in or condone the practice of torture or any form of cruel, inhuman, or degrading procedure.
**Decision-making**

Medical decision-making is ideally a deliberative process that engages the patient in shared decision-making and is informed by the patient’s experience and values and the physician’s clinical judgment. This deliberation involves discussion with the patient and, with consent, others central to the patient’s care (families, caregivers, other health professionals) to support patient-centred care.

In the process of shared decision-making:

11. Empower the patient to make informed decisions regarding their health by communicating with and helping the patient (or, where appropriate, their substitute decision-maker) navigate reasonable therapeutic options to determine the best course of action consistent with their goals of care; communicate with and help the patient assess material risks and benefits before consenting to any treatment or intervention.

12. Respect the decisions of the competent patient to accept or reject any recommended assessment, treatment, or plan of care.

13. Recognize the need to balance the developing competency of minors and the role of families and caregivers in medical decision-making for minors, while respecting a mature minor’s right to consent to treatment and manage their personal health information.

14. Accommodate a patient with cognitive impairments to participate, as much as possible, in decisions that affect them; in such cases, acknowledge and support the positive roles of families and caregivers in medical decision-making and collaborate with them, where authorized by the patient’s substitute decision-maker, in discerning and making decisions about the patient’s goals of care and best interests.

15. Respect the values and intentions of a patient deemed incompetent as they were expressed previously through advance care planning discussions when competent, or via a substitute decision-maker.

16. When the specific intentions of an incompetent patient are unknown and in the absence of a formal mechanism for making treatment decisions, act consistently with the patient’s discernable values and goals of care or, if these are unknown, act in the patient’s best interests.

17. Respect the patient’s reasonable request for a second opinion from a recognized medical expert.

**Physicians and the practice of medicine**

**Patient privacy and the duty of confidentiality**

18. Fulfill your duty of confidentiality to the patient by keeping identifiable patient information confidential; collecting, using, and disclosing only as much health information as necessary to benefit the patient; and sharing information only to benefit the patient and within the patient’s circle of care. Exceptions include situations where the informed consent of the patient has been obtained for disclosure or as provided for by law.

19. Provide the patient or a third party with a copy of their medical record upon the patient’s request, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.

20. Recognize and manage privacy requirements within training and practice environments and quality improvement initiatives, in the context of secondary uses of data for health system management, and when using new technologies in clinical settings.

21. Avoid health care discussions, including in personal, public, or virtual conversations, that could reasonably be seen as revealing confidential or identifying information or as being disrespectful to patients, their families, or caregivers.
Managing and minimizing conflicts of interest

22. Recognize that conflicts of interest may arise as a result of competing roles (such as financial, clinical, research, organizational, administrative, or leadership).

23. Enter into associations, contracts, and agreements that maintain your professional integrity, consistent with evidence-informed decision-making, and safeguard the interests of the patient or public.

24. Avoid, minimize, or manage and always disclose conflicts of interest that arise, or are perceived to arise, as a result of any professional relationships or transactions in practice, education, and research; avoid using your role as a physician to promote services (except your own) or products to the patient or public for commercial gain outside of your treatment role.

25. Take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to a third party when acting on behalf of a third party.

26. Discuss professional fees for non-insured services with the patient and consider their ability to pay in determining fees.

27. When conducting research, inform potential research participants about anything that may give rise to a conflict of interest, especially the source of funding and any compensation or benefits.

Physicians and self

28. Be aware of and promote health and wellness services, and other resources, available to you and colleagues in need.

29. Seek help from colleagues and appropriate medical care from qualified professionals for personal and professional problems that might adversely affect your health and your services to patients.

30. Cultivate training and practice environments that provide physical and psychological safety and encourage help-seeking behaviours.

Physicians and colleagues

31. Treat your colleagues with dignity and as persons worthy of respect. Colleagues include all learners, health care partners, and members of the health care team.

32. Engage in respectful communications in all media.

33. Take responsibility for promoting civility, and confronting incivility, within and beyond the profession. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.

34. Assume responsibility for your personal actions and behaviours and espouse behaviours that contribute to a positive training and practice culture.

35. Promote and enable formal and informal mentorship and leadership opportunities across all levels of training, practice, and health system delivery.

36. Support interdisciplinary team-based practices; foster team collaboration and a shared accountability for patient care.
Physicians and society

37. Commit to ensuring the quality of medical services offered to patients and society through the establishment and maintenance of professional standards.

38. Recognize that social determinants of health, the environment, and other fundamental considerations that extend beyond medical practice and health systems are important factors that affect the health of the patient and of populations.

39. Support the profession’s responsibility to act in matters relating to public and population health, health education, environmental determinants of health, legislation affecting public and population health, and judicial testimony.

40. Support the profession’s responsibility to promote equitable access to health care resources and to promote resource stewardship.

41. Provide opinions consistent with the current and widely accepted views of the profession when interpreting scientific knowledge to the public; clearly indicate when you present an opinion that is contrary to the accepted views of the profession.

42. Contribute, where appropriate, to the development of a more cohesive and integrated health system through interprofessional collaboration and, when possible, collaborative models of care.

43. Commit to collaborative and respectful relationships with Indigenous patients and communities through efforts to understand and implement the recommendations relevant to health care made in the report of the Truth and Reconciliation Commission of Canada.

44. Contribute, individually and in collaboration with others, to improving health care services and delivery to address systemic issues that affect the health of the patient and of populations, with particular attention to disadvantaged, vulnerable, or underserved communities.
Appendix C CoM MD Program Learning Objectives

Program Learning Objectives

Medical Expert
The graduating physician will demonstrate enduring ability to apply and integrate medical knowledge, clinical skills (both cognitive and procedural), and professional attitudes to provide medical care to patients across the spectrum of health (wellness, acute illness, chronic illness) and along the continuum of life. The graduating physician will integrate an understanding of the determinants of health and the modifiers of illness, together with an understanding of the unique characteristics and circumstances of each patient, to guide diagnosis and patient- and family-centered clinical decision-making.

1. Identify normal human development, structure, and function as well as inherent variability for each.
2. Identify the determinants of health at the individual, family, and community level.
3. Describe evidence-informed principles of surveillance and screening for the normal/healthy population and for at-risk populations.
4. Describe how health promotion and public health principles apply to clinical care.
5. Identify individual patient risk factors to develop appropriate care strategies.
6. Explain the spectrum of pathology and presentations of common and/or important acute and chronic diseases.
7. Demonstrate an approach to the diagnosis of common and undifferentiated clinical presentations.
8. Obtain appropriate and accurate patient history through a patient and family-centered interview.
9. Elicit relevant positive and negative physical signs through performance of an appropriate patient-centered physical examination, optimizing patient comfort.
10. Respond appropriately to potentially urgent/emergent conditions in patient care.
11. Develop a relevant prioritized differential diagnosis through clinical reasoning and integration of clinical information.
12. With consideration of patient context, select and interpret results of appropriate and evidence-informed diagnostic tests based on differential diagnosis.
13. Demonstrate proficiency appropriate for level of training in basic procedural skills relevant to clinical care.
14. Develop and implement an appropriate patient-centered and evidence-informed treatment or management plan, including where appropriate pharmacologic and/or non-pharmacologic strategies, multidisciplinary care, patient self-management, and follow up plans.
15. Identify ways to improve patient safety.

Communicator
The graduating physician will demonstrate competence in the use of effective communication skills. The following are determined to be key competencies for the graduating student: Conduct patient centered interviews, demonstrate effective interviewing and listening skills, analyzing patient context, negotiating an effective patient centered management plan, and effectively presenting information to other healthcare professionals involved in patient care.

1. Demonstrate appropriate communication skills.

Program Learning Objectives
Program Learning Objectives

2. Adjust personal communication style to patient’s needs, understanding and content of communication to effectively communicate including in challenging and difficult situations.
3. Effectively present information about clinical encounters and management plans to supervising physicians and/or team members including hand-over of care.
4. Maintain accurate, comprehensive, legible and up-to-date medical record documentation.

Collaborator
The graduating physician recognizes that he/she is one member of a team whose goal is to achieve optimal care for each patient. Care teams are patient-, family-, diagnosis- and situation-specific and their characteristics and composition are fluid over time and across multiple sites or locations. Patients, their families and support systems are integral members of the care team. In addition to patients, families, physicians and other health professionals, the care team may include community and social agencies, educators, faith/cultural support persons, and traditional/alternative healers or service providers.

1. Demonstrate effective team collaboration.
2. Collaborate effectively to access hospital and/or community resources/supports.

Leader
Physicians are integral participants in the health care of individuals and in the function of healthcare organizations. Physicians have a primary fiduciary responsibility to each individual patient but also a broader societal responsibility for prudence and wisdom in the use of scarce resources. Physicians are a resource to patients, their families, communities and populations. Physicians manage their personal, family and professional lives and their working relationships with employees, colleagues and other health care workers using effective processes of leadership, human resource and financial management. Physicians use information systems and practice management tools to coordinate care and ensure efficient and effective care. The graduating physician will have foundational knowledge of these principles and emerging competence in the areas of self-directed and self-managed professional practice.

1. Explain the best use of resources when making equitable patient-centered clinical and population healthcare decisions.
2. Employ information technology effectively for patient care.
3. Manage workload effectively.
4. Participate in career planning.

Health Advocate
Physicians use their expertise (knowledge) and influence (social, political, financial) to advance the health and well-being of individual patients, communities, and populations. Physicians contribute actively to the development of public policy, particularly in the areas affecting the determinants of health and access to
Program Learning Objectives

care. Graduating physicians will recognize and attempt to balance competing backgrounds, interests and needs as they develop personal professional competency in this domain.

1. Identify vulnerable individuals and populations.
2. Identify opportunities and, where possible, solutions for patient and/or community advocacy.

Scholar
The graduating physician recognizes the need for and commits to the process of lifelong reflective learning. The graduating physician accepts the responsibility to share, translate, teach, and enhance medical knowledge for the benefit of patients, students, colleagues, and society as a whole.

1. Demonstrate self-directed learning including utilizing appropriate resources and critical research appraisal strategies.
2. Describe the principles of evidence-informed medicine.
3. Describe the principles of quality improvement/assurance and relevance to patient care and safety.
4. Apply the principles of healthcare research.
5. Participate in education of others.

Professional
The graduating physician accepts the tenets of the profession: commitment to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high standards of personal behavior. Physicians are guided by codes of ethics, committed to clinical excellence, and embrace appropriate attitudes and behaviors, including honesty, altruism, integrity, commitment, compassion, respect, and the promotion of the public good.

1. Demonstrate professional behavior informed by ethical/legal standards and awareness of personal wellness and limitations.
2. Describe current ethical and legal principles important in medicine including those related to informed consent, capacity, patient autonomy, privacy and confidentiality.
3. Explain the evolving contract between physicians, their organizations and society.
4. Demonstrate culturally safe and respectful care of all patients including First Nations, Inuit, and Metis.
Appendix D CoM Standard Operating Procedure-Undergraduate Medical Education: Procedure for Concerns with Medical Student Professional Behaviour

UNIVERSITY OF SASKATCHEWAN
College of Medicine

STANDARD OPERATING PROCEDURE
Undergraduate Medical Education
Procedure for Concerns with Medical Student Professional Behaviour

SOP Number 00000
SOP Title Procedures for Concerns with Medical Student Professional Behaviour

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<td>Author</td>
<td>Dr. Patricia M. Blakley</td>
<td>Associate Dean, Undergraduate Medical Education</td>
<td>2 May 2017</td>
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<td>Reviewer</td>
<td>Dr. Meredith McKague</td>
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<td>2 May 2017</td>
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<tr>
<td>Authoriser</td>
<td>Dr. Kent Stobart</td>
<td>Vice Dean, Education</td>
<td>31 July 2017</td>
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Effective Date: 31 July 2017
Review Date: July 2019

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<td>Year 1 Chair</td>
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<td>Dr. Schaana Van de Kamp</td>
<td>Year 2 Chair</td>
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<td>Year 3 Chair</td>
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<td>Year 4/5 Chair</td>
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<td>Dr. Bindu Nair</td>
<td>Assistant Dean, Student Services</td>
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<td>Sherry Pederson</td>
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<td>Kiefer Lypka, Jeffrey Elder,</td>
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<td>Adrianna Gunton, Odell Tan</td>
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1. **PURPOSE**

The purpose of the Procedures for Concerns with Medical Student Professional Behaviour is to articulate the implementation of the Regulations on Student Academic Misconduct and Standard of Student Conduct in Non-Academic Matters and Regulations and Procedures for Resolution of Complaints and Appeals within the College of Medicine. This provides transparent processes for responding to concerns of lapses in professional behaviour by medical students. It is the expectation that medical students as junior colleagues and members of the medical profession are held accountable to the same standards as professionals in the medical field. The Procedures are intended to be consistent with the College of Medicine, College of Physicians and Surgeons of Saskatchewan and the Canadian Medical Association Code of Ethics for clinical faculty. Specifically both medical students and clinical faculty will be expected to adhere to the same principles of professionalism.

These procedures ensure that the Undergraduate Medical Education program meets or exceeds the following Committee on Accreditation of Canadian Medical Schools (CACMS) accreditation standards:

**3.5 Learning Environment/Professionalism:** A medical school ensures that the learning environment of its medical education program is conducive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations and is one in which all individuals are treated with respect. The medical school and its clinical affiliates share the responsibility for periodic evaluation of the learning environment in order to identify positive and negative influences on the maintenance of professional standards, implement appropriate strategies to enhance positive and mitigate negative influences, and identify and promptly correct violations of professional standards.

2. **SCOPE**

These procedures apply to instances where undergraduate students registered in the Doctor of Medicine (MD) program at the University of Saskatchewan, irrespective of the geographically distributed site to which they are currently assigned, engage in behaviour which is generally recognized as being unprofessional.

3. **DEFINITIONS**

**Reporter:** a person who submits a report of unprofessional behaviour. Typically this will be a lecturer, Module/Clerkship Core Rotation/Course Director, Course Chair or Year 1 – 4 Chair/Site Coordinator. This may also include a staff member in the College of Medicine or Health Region or a clinical preceptor or other medical student or medical resident.

**Respondent:** a person alleged to have engaged in unprofessional behavior. This will typically be an undergraduate student registered in the Doctor of Medicine (MD) program at the University of Saskatchewan. This may also include students from other medical schools who are participating in a visiting clinical elective in the College of Medicine at the University of Saskatchewan. Unprofessional behavior of medical students on visiting clinical electives will
be reported to the Associate Dean Undergraduate Medical Education at the student’s home institution for management.

**Minor Incident:** an incident that has minimal consequence. Examples of unprofessional behaviour include but are not limited to:

- Submitting an assignment late
- Arriving late for a mandatory lecture or clinical learning experience
- Missing a mandatory session
- Presenting an appearance that may not be perceived by patients as professional
- Using language in email, assignment or other communication that may be overly casual or may be perceived as otherwise inappropriate or disrespectful
- Receiving or responding to feedback inappropriately
- Failing to promptly return phone calls and emails, or other communication unrelated to patient care
- Incidents of academic misconduct in which the reporter perceives that the student’s misconduct was minor and unintentional, due to a lack of understanding of expectations, rather than intentional

**Major Incident:** an incident that has the potential for serious consequences. Examples of unprofessional behaviour include but are not limited to:

- Failing to return phone calls and emails when patient care may be compromised
- Demonstrating a pattern of not responding to call for assistance (when on call or expected to be available)
- Failing to communicate, in a timely manner, absences due to illness or other reason
- Most incidents of academic misconduct, including lying or misrepresenting himself/herself including instances of academic dishonesty such as taking credit for someone else’s ideas, plagiarism, cheating and falsifying information (research data, grades, assessment results)
- Posting patient information on a social networking website
- Sharing patient information in a public space
- Engaging in inappropriate and/or offensive communication with colleagues
- Inappropriate communication whether on social media/ internet, in person or other means including shaming others publicly, exhibiting uncontrolled anger; displaying inappropriate pictures from research, education or clinical settings through social media;
- Inappropriate communication may also include the use of unacceptable words, images, or actions such as profane or disrespectful language; inappropriate labels or name-calling; patronizing and insulting remarks; intimidating gestures by slamming doors or throwing things;
- Uncooperative behaviors, whether intentional or not, such as repeated refusals to comply with known and accepted practice standards;
- Refusal to work collaboratively with colleagues, staff and patients;
Critical Incident: an incident which has direct harmful consequences or is an egregious breach of well-recognized standards. Examples include but are not limited to:

- Physically or sexually assaulting a patient
- Being sexually inappropriate with a patient or co-worker
- Unwelcome and inappropriate verbal, written, graphic or physical conduct, or coercive behavior, where the behavior is known or reasonably ought to be known to be unwelcome
- Unauthorized release of confidential information including identifiable personal data of a research participant; a patient’s health information or other breach of personal information, privacy policy and law Freedom of Information and Protection of Privacy Act (FOIP), the Local Authority Freedom of Information and Protection of Privacy Act (FIPPA), Health Information Protection Act (HIPA)
- Inappropriately accessing or using a co-worker, learner, research participant or patient’s personal information

4. GUIDING PRINCIPLES

In the teaching and learning of Medicine, professionalism is a core academic competency and is continuously being assessed throughout the undergraduate medical education program. Clinical courses include professionalism as a component to be taught and assessed. These procedures are not intended to override course-related assessment processes or documentation. The primary intention of these procedures is to provide an effective mechanism for the early identification of students who need assistance with their professional development so that appropriate remediation can be implemented in support of their successful completion of the program. They should be considered when unprofessional conduct is identified that is outside the developmental norms for a student’s cohort. The secondary intention of these procedures is to assist with crucial academic decisions when remediation is unsuccessful or inappropriate.

These procedures cover most allegations of unprofessional behaviours that occur in academic or clinical settings or other work placements, or that are related to the student’s area of professional study and are informed by the following guiding principles:

Respect for others

Professionals demonstrate consideration and respect for others including patients, their families and support persons, colleagues, classmates, teachers, other professionals and the public.

- We don’t allow our conduct to negatively impact on others’ learning or clinical activities
- We don’t discriminate against others on the basis of such grounds as age, race, colour, ancestry, place of origin, ethnicity, political beliefs, religion, marital status, family status, physical or mental disability, sex, sexual orientation or gender identity
We demonstrate respect for the dignity and rights of patients and their families or support persons, taking into account their diversities, both in their presence and in discussion with other members of the health care team.

We accept and promote patient autonomy in decision-making, and when the patient lacks capacity, we consult with and appropriately take direction from surrogate decision-makers.

We respect the personal boundaries of others and refrain from making unwanted or inappropriate romantic or sexual overtures towards others.

We communicate respectfully with others both verbally and in writing.

We respect the privacy and confidentiality of those to whom we owe that duty.

**Honesty and integrity**

Professionals demonstrate adherence to the highest standards of personal, professional and academic honesty and integrity.

- We communicate truthfully with others verbally and in writing.
- We don't falsify documents or records.
- We acknowledge and manage conflicts of interest appropriately, avoiding conflicts of interest, real or apparent, whenever there is potential detriment to others.
- We admit and disclose errors.
- We make accurate records of conversations, histories, physical findings and other information pertinent to patient care.
- We don't engage in plagiarism, nor do we give or receive assistance during an examination or in completion of an assignment unless such is expressly permitted.
- We conduct research in an ethical manner, analyzing and reporting results accurately and fairly.
- We credit the ideas and work of others appropriately and fairly.

**Compassion and empathy**

Professionals demonstrate compassion and empathy for those in distress and especially for patients, their families and support persons.

- We demonstrate effective listening.
- We are aware of and respectful of others' differences and respond appropriately to their needs.
- We show compassion and provide support for patients, their families and support persons dealing with illness and/or dying and death.

**Duty and responsibility**

Professionals acknowledge their duties to patients, their profession and society and accept the responsibilities that flow from these duties.

- We attend to patients' best interests and well-being as the first priority.
• We work cooperatively with others for the benefit of our patients and contribute to a healthy working environment for all
• We make equitable and prudent use of health care resources under our control
• We are responsible to society for matters relating to public health
• We recognize and adhere appropriately to policies, codes, guidelines and laws that govern us and our work
• We participate in the process of self-regulation of the profession
• We address misconduct, incompetence or behaviours that put patients or others at risk
• We share resources and expertise, and assume responsibility for our portion of a fairly distributed workload; where issues of fair distribution arise, we act most immediately in the patient’s best interests, and seek to resolve issues of fairness through appropriate channels
• We respond in an appropriate, non-judgmental and non-demeaning manner when our expertise is sought
• We don’t take advantage of colleagues, learners, patients, their families or support persons or others for emotional, financial, sexual or other personal purposes, and we conduct research and educational activities with these groups only with appropriate informed consent
• We fulfill commitments, meet deadlines and are punctual particularly where these behaviours have significant impact on others; where we’re unable to do so, we communicate appropriately to mitigate any negative impacts
• We engage in lifelong learning, maintain clinical competence and strive for continuous quality improvement
• We take appropriate and necessary responsibility for our personal health and well-being
• We recognize our own limitations and seek assistance appropriately
• We display dress, behaviour and demeanor in the educational and healthcare setting in keeping with appropriate pedagogical, clinical or safety standards

Used with Permission Dalhousie University Faculty of Medicine “Dalhousie Medical School Professionalism Committee Professionalism Policy”.

5. RESPONSIBILITIES
The Associate Dean, Undergraduate Medical Education is responsible for the oversight and implementation of the Procedure for Concerns with Medical Student Professional Behaviour.

6. SPECIFIC PROCEDURE
6.1 Reporting a Minor Incident
Many cases of alleged unprofessional conduct on the part of students result from misunderstanding or lack of familiarity with the expected standards. Examples of minor incidents are indicated in 3.0 Definitions. A case of this kind can often be addressed through an informal meeting with the student (respondent) by a reporter who first identifies the issue (Appendix A). Generally, a conversation and feedback may be sufficient, although it may also be reasonable to expect that the student will address the
issue in a manner mutually agreed upon. The reporter will document the discussion with the student and complete an Informal Discussion Form. The student will be provided a copy in order to document their understanding of the discussion. The Informal Discussion Form will be submitted to the Year Chair who will maintain a confidential file of these forms.

At the end of the Academic Year the Year Chair will provide to the Associate Dean, Undergraduate Medical Education, the Informal Discussion Forms that had been incurred by the students that have not met the threshold for a Professionalism Concern Form. This would include students who have received 2 or less Informal Discussion Forms. This information will not be forwarded to subsequent Year Chairs but may be used to identify a pattern of behaviour. Should a pattern of behaviour be identified, the student will be contacted by the Associate Dean, Undergraduate Medical Education.

If a student incurs multiple (3 or more) Informal Discussion Forms of a similar type (e.g. late assignments) or multiple (3 or more) Informal Discussion Forms of different types (e.g. 1 late assignment, 1 episode of being late for a lecture and 1 missed mandatory session), then the Year Chair will meet with the student. The Year Chair will document the meeting and will complete a Professionalism Concern Form. The student will have an opportunity to include a comment in the Report. The Professionalism Concern Form will be submitted to the Associate Dean, Undergraduate Medical Education. The Report will be placed on the student’s Professionalism File. No further action will occur at that time.

If a student incurs a subsequent minor incident after receiving a Professionalism Concern Form the Year Chair will submit a second Professionalism Concern Form. The Associate Dean, Undergraduate Medical Education will inform the student that a consultation about the matter will be made to the Professionalism Panel. The Panel will meet to determine whether a Formal Professionalism Hearing is required. If the Panel determines that a Formal Hearing is not required, the student will be notified and the student will have a meeting with the Associate Dean, Undergraduate Medical Education. The student will receive a note indicating the discussion and identified plan resulting from the meeting. If the Panel determines that a Formal Hearing is required, then the student will be notified and a Hearing will be held. The process for a Formal Hearing of the Professionalism Panel is described in 6.4 The Panel’s decision and recommendations will be communicated to the Associate Dean, Undergraduate Medical Education.

6.2 Reporting a Major Incident
A Major Incident is one that has the potential for serious consequences to patients, peers, staff and faculty. A Major Incident may also include incidents that have the potential to damage the reputation of the College of Medicine. Examples of Major Incidents can be found in 3.0 Definitions. The procedure for reporting a Major Incident is shown in Appendix B. When a student is alleged to have engaged in a Major Incident, the reporter submits an Informal Discussion Form to the Year Chair, who subsequently meets with the student to discuss the incident. The Year Chair will document the meeting and will complete a Professionalism Concern Form. The student will have an opportunity to include a comment
in the Report. The Professionalism Concern Form will be submitted to the Associate Dean, Undergraduate Medical Education.

The Associate Dean, Undergraduate Medical Education will inform the student that a consultation about the matter will be made to the Professionalism Panel. The Panel will meet to determine whether a Formal Professionalism Hearing is required. If the Panel determines that a Formal Hearing is not required, the student will be notified and student will have a meeting with the Associate Dean Undergraduate Medical Education. If the Panel determines that a Formal Hearing is required, then the student will be notified and a Hearing will be held. The process for a Formal Hearing of the Professionalism Panel is described in 6.4. The Panel’s decision and recommendations will be communicated to the Associate Dean, Undergraduate Medical Education.

6.3 Reporting a Critical Incident

A Critical Incident is an incident which has direct harmful consequences or is an egregious breach of well-recognized standards. Because of the nature of the incidents as evidenced by the examples identified in 3.0 Definitions, the reporting of a Critical Incident is anticipated to follow most closely the processes utilized in the University of Saskatchewan Regulations on Student Academic Misconduct (2017) and Standard of Student Misconduct in Non-Academic Matters and Regulations & Procedures for Resolution of Complaints and Appeal (2016).

The procedure for reporting a Critical Incident is shown in Appendix C. When a student is alleged to have engaged in a Critical Incident, the reporter submits a Professionalism Concern Form to the Associate Dean, Undergraduate Medical Education who will then file a formal complaint pursuant to the University of Saskatchewan Regulations on Student Academic Misconduct (2017) and Standard of Student Misconduct in Non-Academic Matters and Regulations & Procedures for Resolution of Complaints and Appeal (2016). In the former case the Professionalism Panel will serve as the College of Medicine’s Hearing Board as designated by the Dean, while in the latter the complaint is adjudicated by the University Secretary who may convene a Formal Hearing before the Senate Hearing Board. The relevant university-level regulations are as follows:

- University of Saskatchewan Regulations on Student Academic Misconduct (2017)
- University of Saskatchewan Standard of Student Misconduct in Non-Academic Matters and Regulations & Procedures of Complaints and Appeal (2016)

If the Critical Incident has the potential to significantly impact the safety or wellbeing of others, particularly patients, the Associate Dean, Undergraduate Medical Education may interrupt the participation of the student in clinical activities pending investigation of the allegations. In such cases, the Professionalism Panel would proceed as quickly as possible and, as soon as safety is established, would communicate to the Associate Dean, Undergraduate Medical Education that the student can resume clinical activities.
6.4 Process for a Formal Hearing of the Professionalism Panel

All Panel proceedings should be based on sound principles to ensure a fair hearing within a reasonably short period of time. The respondent is to be treated as innocent until proven guilty and there must be the both the perception and reality that all hearings are fair and transparent. The primary goal of the process should be educational, leading to the successful remediation of unprofessional conduct and the subsequent successful completion of the program.

The Panel is to receive the evidence, determine the validity of the allegation and, if warranted, determine, implement and monitor appropriate remedial action. The Panel will also determine whether there should be academic repercussions. Where possible, the Panel will meet within four weeks from receipt of the Professionalism Concern Form.

The Associate Dean Undergraduate Medical Education will write to the respondent as soon as possible advising him/her of the allegation, the date and place of his/her meeting with the Panel and the Panel membership so that potential conflicts of interest can be identified. This notice will consist of both a letter to the respondent’s current postal address on file with the University and an email to the respondent’s usask email account. The respondent will be provided with approximately 2 weeks’ notice of the meeting date.

All information provided to the Panel in writing in advance of the meeting by any party should be shared in advance with the other parties appearing before the Panel in advance of the meeting.

The Professionalism Panel is composed of a chairperson who is an MD faculty member and two members of the faculty of the college, at least one of whom will be an MD. The Professionalism Panel is appointed by the Vice Dean, Education to staggered three-year terms and may be re-appointed for a second term. It is recommended that at least one Panel member be experienced in the assessment of professionalism through prior or current participation in relevant activities of the College of Physicians and Surgeons of Saskatchewan. The Panel maintains its own records, separate from respondents’ academic files. The chairperson is an ex-officio member of the Student Academic Management Committee.

The Associate Dean, Undergraduate Medical Education, in consultation with the Student Medical Society of Saskatchewan executive, will appoint to the Professionalism Panel a more senior student from the MD program or, in the case of a respondent who is a final year student, from the first postgraduate year of medical training. The selection of the student may be challenged by the respondent if there is reasonable apprehension of bias or conflict of interest. Further, the respondent may choose to waive the requirement for student representation.

The Panel will meet with the respondent and the reporter at the same time. The Panel may, at its discretion, meet with any other person who, in the opinion of the board, can provide relevant evidence bearing on the matter. The Panel may set its own procedures. A suggested order of proceeding is as follows: The reporter outlines the evidence before the Panel followed by questions and points of clarification asked by the Panel members. The
respondent is then allowed to express his/her side of the question followed again by
questions and points of clarification asked by the Panel members. Questions for clarification
purposes may then also be asked through the Panel chair by the respondent and by the
reporter. After all questions have been answered and all points made, the Panel will meet in
camera to decide on the question of validity and, if valid, an appropriate
response/remediation plan. The decision and plan, if applicable, will be communicated to the
respondent and the reporter in writing as soon as is possible after the hearing. The
respondent and the reporter will be advised that either may appeal by the process identified
in Section 6.5.

At the hearing, the respondent has the right to be accompanied by another person of his/her
choice. The Office of Student Affairs is available for this purpose, but the respondent may
make a different choice. This may include a class representative who may serve as support or
character reference.

Similarly, the reporter may be accompanied by a person of his/her choice. On request, the
Associate Dean will provide information and assistance in the identification of a suitable
escort who is familiar with the procedures associated with this policy.

If the respondent does not respond to the written/email notification of the hearing, or
refuses to appear before the Panel, or does not attend the hearing, the Panel has the right to
proceed with the hearing. It is obviously in the respondent’s interests to be present for the
hearing, but the Panel should not be prevented from holding a hearing because the
respondent has not appeared.

When the reporter is not a member of the university community, and with the agreement
of the Panel members, the respondent may waive the requirement that the reporter be
present in person; this assumes that the written documentation is clear and uncontested. In
addition, a teleconference or a videoconference may be considered.

In circumstances in which the reporter is particularly vulnerable, the Chair of the
Professionalism Panel may, at his/her discretion, permit the reporter to name a proxy to act
on the reporter’s behalf.

When a set of circumstances has led to allegations of unprofessional conduct against two or
more respondents, the investigation may include an opportunity for any or all of the
respondents to be interviewed separately. In a case where the unprofessional conduct is
ascribed to a group of students, the Panel will try to determine if one person is responsible,
or whether varying degrees of responsibility can be delineated. If individual responsibility
cannot be determined, the whole group may be sanctioned.

If a majority of members of a Panel conclude that the allegation of unprofessional conduct is
supported by the evidence before the Panel, it may recommend one or more of the following
responses:

- that a remediation plan specific to the issues at hand be implemented, to be developed
  and monitored by the Panel;
that there be a referral for assessment of possible medical and/or psychosocial issues at play, to be reported back to the Panel for further action and/or referral as necessary;
- that there be a record of the event(s) placed in the respondent’s academic file for use in the Medical Student Performance Record;
- that the respondent be required to repeat the year of the MD program during which the unprofessional conduct was identified;
- that the respondent be suspended from the program for a specified period of time;
- that the respondent be expelled from the University; or
- that the conferral of a degree, diploma or certificate be postponed, denied or revoked.

When determining the appropriate response, the Panel will take into account responses imposed for similar unprofessional conduct as recorded by the Associate Dean, Undergraduate Medical Education, as well as any record of previous reports of unprofessional conduct by the respondent(s). It is intended that most incidents be addressed in a remedial fashion, without adverse impact on the respondent’s academic progress or record. However, repeated and refractory unprofessional conduct, or single incidents of particularly egregious conduct, may lead to the recommendation for academic repercussions as delineated above.

The chairperson of the Panel will prepare a report of the board’s deliberations which will summarize the evidence on which the board based its conclusion that unprofessional conduct occurred and state the recommended response(s). Not later than 15 days after the Panel has completed its deliberations, the chairperson will deliver a copy of the report to the following persons:
- to the respondent;
- to members of the Panel;
- to the Associate Dean, Undergraduate Medical Education;
- to the Chair of the Student Academic Management Committee, only if it is the decision of the Panel to recommend academic repercussions;
- to the Registrar of the University of Saskatchewan, only if it is the decision of the Panel to recommend academic repercussions.

When a Panel concludes that an allegation is not supported by the evidence, the report will so state. A recommendation of a Panel is deemed to have been adopted unless it is appealed.

6.5 Appeals Process

A respondent who has appeared before the Professional Panel for Minor or Major Incidents and who has had an action recommended may appeal the recommendation of the Professionalism Panel by delivering a notice of appeal to the Associate Dean Undergraduate Medical Education by 15 days from the date a copy of the Panel report was delivered to the respondent. The Associate Dean Undergraduate Medical Education will send a request to the Chair of the Academic Appeals Committee to hear the appeal. The Academic Appeals Committee will hear the appeal within 15 days to consider the appeal.
A respondent or complainant who has appeared before the Professionalism Panel as the Hearing Board pursuant to the University of Saskatchewan Regulations on Student Academic Misconduct (2017) may appeal recommendations of the Panel by delivering to the University Secretary a written notice of appeal within 30 days from the date a copy of the hearing board report was delivered to the person.

A respondent or complainant who has appeared before the Senate Hearing Board pursuant to the University of Saskatchewan Standard of Student Misconduct in Non-Academic Matters and Regulations & Procedures of Complaints and Appeal (2016) may appeal recommendations of the Senate Hearing Board by delivering to the University Secretary a written notice of appeal within 30 days from the date a copy of the hearing board report was delivered to the person.

6.6 Professionalism Files

Professionalism files are securely stored, in physical or electronic format, in the office of the Associate Dean, Undergraduate Medical Education. They are retained for the entire duration of a medical student’s academic program and are destroyed two years after a student’s graduation, dismissal, withdrawal or death.

6.7 Communicating the Procedures

The College of Medicine will communicate the Procedure for Concern with Medical Student Professional Behaviour to faculty, staff, and students by ensuring that up-to-date versions of this procedure is publically available on the college website.

Furthermore, the Undergraduate Medical Education Office shall further communicate this procedure by providing a written copy of this document to medical students in their first-year orientation package.

7. FORMS/TEMPLATES TO BE USED

Informal Discussion Form
Professionalism Concern Form
Appendix A – Minor Incident
Appendix B – Major Incident
Appendix C – Critical Incident

8. INTERNAL AND EXTERNAL REFERENCES

8.1 Internal References

Regulations on Student Academic Misconduct

Standard of Student Conduct in Non-Academic Matters and Regulations and Procedures for Resolution of Complaints and Appeals
8.2 External References

Dalhousie Medical School Professionalism Committee Professionalism Policy

Queen’s University Undergraduate Medical Education Student Professionalism Policy

CMA Code of Ethics

College of Physicians and Surgeons of Saskatchewan - Regulatory Bylaws for Medical Practice in Saskatchewan (February 2017)

9. CHANGE HISTORY

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Page 13 of 13
Appendix E CoM Undergraduate Medical Education Program Informal Discussion Form

UNDERGRADUATE MEDICAL EDUCATION PROGRAM
INFORMAL DISCUSSION FORM

Minor Incident: This form may record a minor incident as reported by any person ("the reporter") in contact with a medical student in any official capacity. The reporter would typically be a lecturer, Module/Clerkship Core Rotation/Course Director/Course Chair or Year 1 - 5 Chair/Site Coordinator, or another medical student or medical resident. The purpose of reporting a minor incident is to initiate a meeting between a medical student and the reporter.

Student Name: ______________________________________

Year: Select Year

Date incident occurred: ______________________________________

A medical student of University of Saskatchewan College of Medicine is expected to demonstrate in her/his behaviours as a medical student: a) Respect for others; b) Honesty and integrity; c) Compassion and empathy; d) Duty and responsibility.

In my opinion, the student named above has demonstrated behaviour(s) that fall below the expected standards of professionalism of our College of Medicine. Following is a brief description of the incident, the response/action taken, and any further comments:

Description of the incident:
This incident was discussed with the student (check one):  

☐ YES  ☐ NO

Student response:  

☐ The Student chose not to respond

A copy of this form is to be provided to the student by the UGME Office

This form should be sent in confidence to:
Year Chair, UGME Office
B526, 107 Wiggins Road Saskatoon, SK S7N 5E5 Fax: (306) 966-2601

Form completed by: ________________________________
Signature: ________________________________
Date: ________________________________

This section for use by Year Chair:
☐ First Minor Incident  ☐ Third Minor Incident: If third minor incident, Year Chair completes a Professionalism Concern Form
☐ Second Minor Incident

Signature of Year Chair: ________________________________  Date submitted: ________________________________
Appendix F CoM Undergraduate Medical Education Program Professionalism Concern Form

UNDERGRADUATE MEDICAL EDUCATION PROGRAM PROFESSIONALISM CONCERN FORM

Minor Incident: This form records >3 minor incidents as reported by any person ("the reporter") in contact with a medical student in any official capacity. The reporter would typically be a lecturer, Module/Clerkship Core Rotation/Course Director/Course Chair or Year 1-5 Chair/Site Coordinator or another medical student or medical resident. The purpose reporting a minor incident is to initiate a meeting between a medical student and the reporter.

Major or Critical Incident: This form may record a major incident or critical incident. Such an incident would typically be reported by the Year 1-5 Chair/Site Coordinator or Associate Dean, Undergraduate Education. The purpose of reporting a major or critical incident is to document more serious concerns of unprofessional behaviour that requires documentation on the student’s Professionalism File or submission to the Professionalism Panel.

Student involved in (check one):  
☐ Multiple Minor Incidents (submit to Associate Dean, UGME)  
☐ Major Incident (submit to Year Chair)  
☐ Critical Incident (submit to Associate Dean, UGME)

Student Name: ________________________________  
Year: ________________________________  
Date incident occurred: ________________________________

Form completed by (please print): ________________________________  
Signature: ________________________________  
Date: ________________________________

A medical student of University of Saskatchewan College of Medicine is expected to demonstrate in her/his behaviours as a medical student: a) Respect for others; b) Honesty and integrity; c) Compassion and empathy; d) Duty and responsibility.

In my opinion, the student named above has demonstrated behaviour(s) that fall below the expected standards of professionalism of our College of Medicine. Following is a brief description of the incident, the response/action taken, and any further comments:

Page 1 of 3
Description of incident:

This incident was discussed with the student (check one):  
☐ YES  ☐ NO

Student response:  
☐ The student chose not to respond

A copy of the form will be provided to the student by the UGME Office

This form should be sent in confidence to:  
Year Chair, UGME Office, or Associate Dean UGME  
B526, 107 Wiggins Road Saskatoon, SK S7N 5E5  
Fax: (306) 966-2601
This section for use by Year Chair:

☐ Third Minor Incident
☐ Previous Professionalism Concern Form
☐ Major Incident

Signature of Year Chair:_________________________ Date:______________________

This section for use by Associate Dean, UGME

☐ Forwarded to Professionalism Panel/University Secretary for review:

Signature:_________________________ Date:______________________

☐ For Professionalism File ☐ For Academic File ☐ For MSPR

Signature:_________________________ Date:______________________

☐ Student notification of Appeal Process

Signature:_________________________ Date:______________________
Appendix G CoM Procedure Flowcharts for Concerns with Medical Student Professional Behaviour (Minor Incident, Major Incident, and Critical Incident)

APPENDIX A: Procedures for Concerns with Medical Student Professional Behaviour

APPENDIX B: Procedures for Concerns with Medical Student Professional Behaviour – Major Incident
APPENDIX C: Procedures for Concerns with Medical Student Professional Behaviour – Critical Incident

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<table>
<thead>
<tr>
<th>Reporter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submits a Professionalism Concern Form</td>
</tr>
<tr>
<td>Associate Dean, UGME</td>
</tr>
<tr>
<td>Meets with student</td>
</tr>
<tr>
<td>Documents meeting &amp; files a formal complaint to the University of Saskatchewan</td>
</tr>
</tbody>
</table>

- **Academic Misconduct**
  - Follow procedure of the Regulations on Student Academic Misconduct (2017)

- **Non-Academic Misconduct**
```
Appendix H CoM Undergraduate Medical Education Assignment Submission Policy

Undergraduate Medical Education Assignment Submission Policy

Category: Academic
Number: TBD
Responsibility: Associate Dean, Undergraduate Medical Education
Approval: Undergraduate Medical Education Curriculum Committee
Date initially approved: December 20, 2016
Date reformatted or revised: November 2019
Date for review: 2022

Purpose:

The purpose of the Undergraduate Medical Education Assignment Submission Policy is to establish the policy governing assignments submitted after the due date within the undergraduate medical education program (UGME) at the University of Saskatchewan.

Principles:

It is the expectation that all assignments will be submitted on time, as this is an element of professionalism.

Definitions:

None.

Scope of this Policy:

This policy applies to all undergraduate students registered in the Doctor of Medicine (MD) program at the University of Saskatchewan irrespective of the geographically distributed site to which they are currently assigned.

Policy:

1.0 Late Assignments

Any assignment submitted after 23:59 SK time on the specified date is deemed late (unless otherwise specified).
All due dates or timelines for assignment submission are published in the student course syllabus¹.

A late assignment submitted up to three consecutive calendar days (72 hours) from the original deadline qualifies to receive partial credit as indicated below. The assignment must be submitted to the appropriate year Administrative Coordinator in Saskatoon, or the Educational Consultant in Regina for years 1-2. Years 3-4 must submit to the Rotation Coordinator. The student, if submitting a late assignment that is deemed to be at or above the pass mark for that assignment will receive the pass mark for the assignment. If it is assessed as below the pass mark, the student will receive the actual grade assigned for the assignment.

Any late assignments not submitted by 23:59 on the third day will receive a mark of 0%. After this period, all mandatory assignments must still be submitted, or the student will be deemed to be missing a course component, which will result in an incomplete course. Subsequent academic consequences will be determined at the promotions committee meetings.

In addition to the consequences specified herein, students submitting mandatory assignments late should anticipate a meeting to discuss professionalism, which may result in associated documentation.

**All requests for a deferral of an assignment due date must be received a minimum of 72 hours prior to the deadline.** All such requests must be sent to the Course Director or Rotation Coordinator and copied to the relevant Administrative Coordinator. The course director, in consultation with the year chair and appropriate course/module/rotation director will make a final decision and notify the student of the outcome. Exceptional, unforeseen circumstances will be considered on an individual basis as above.

**2.0 Exceptions**

Any exceptions to the policy must be approved by the Curriculum Committee.

**Responsibilities**

The Associate Dean, Undergraduate Medical Education, is responsible for providing oversight to the overall administration of the Undergraduate Medical Education Assignment Submission Policy at the University of Saskatchewan.

The Manager, Undergraduate Medical Education, is responsible for the implementation, monitoring, maintenance, and evaluation of the Undergraduate Medical Education Assignment Submission Policy at the College of Medicine. This includes the development and stewardship of the standard operating procedures associated with this policy.

¹ Blackboard routinely updates their systems on certain Wednesday evenings. In the event that Blackboard is down for scheduled maintenance or due to technical difficulties, assignments are to be submitted by 0900 the following morning.
The Curriculum Committee with input from the Assessment Sub-Committee is responsible for evaluating, reviewing, and updating this policy every three years.

**Non-compliance:**

Instances or concerns of non-compliance with the *Undergraduate Medical Education Assignment Submission Policy* should be brought to the attention of the Vice-Dean, Education or the Associate Dean, Undergraduate Medical Education, within the College of Medicine.

**Procedures:**

Procedures for this policy will be maintained by the Associate Dean, Undergraduate Medical Education.

**Contact:**

Dr. Greg Malin  
Director, Academic  
Phone: 306-966-2750  
Email: greg.malin@usask.ca
Appendix I.1 CoM MD Program Pre-clerkship Attendance and Absence Policy Overview

MD Program Pre-Clerkship Attendance and Absence Policy Overview

Responsibility: Assistant Dean Academic
Approval: Student Academic Management Committee

Date:
Approved: Student Academic Management Committee, Aug 8 2016
Revised: Student Academic Management Committee, Apr 6 2017
Revised: Student Academic Management Committee, Apr 10 2018
Revised: Student Academic Management Committee, Aug 3 2018
Revised: Student Academic Management Committee, May 9 2019

Purpose:
The purpose of this policy is to provide clear and consistent expectations for students, staff and faculty related to student attendance in the pre-clerkship portion of the MD program.

Other related documents are the Student Leadership Absence Policy, Clerkship Attendance and Absence Policy, and Procedure for Procedure for Session Attendance Across Sites/ Campuses.

Principles:
Active participation by medical students in learning opportunities is critical to their formation, education, and training. Sustained and deep engagement, which requires regular and punctual attendance, is expected of all students in all of their classes (lectures, laboratories, seminars, tutorials, small groups and clinical sessions). Students who neglect their academic
responsibilities may be excluded from final examinations and this behaviour will be addressed through the Procedures for Concerns with Medical Student Professional Behaviour.

The College of Medicine recognizes that medical students are adult learners and entitled to the privileges and responsibilities that come with such status. That being said, for many components of the program, the College of Medicine relies heavily upon faculty with clinical obligations, their patients and other patient volunteers. Absenteeism and lack of punctuality by students place an unwelcome strain on the goodwill of all concerned. Often a significant degree of accommodation has occurred to make these educational experiences possible. Replicating these experiences to accommodate student absences is extremely difficult. Acceptance of responsibility for attendance and participation in patient care is part of the student’s professional education and responsibility. Appropriate attendance and punctuality are indicative of the student’s understanding of, and adherence to, expectations of professional behaviour.

It has been the College’s experience that, for some students, chronic non-attendance often ends up in academic and/or professional difficulty. Students also end up feeling disengaged and separated from their class cohort, which can further affect academic success because of a lack of peer support. The College reserves the right to mandate attendance by those students who are in academic or professional difficulty. Such circumstances would be clearly documented and provided in writing to the student.

**Definitions:**

**Pre-clerkship:** The first and second years of the University of Saskatchewan Undergraduate Medical Education Program (UGME) are termed “pre-clerkship”. During this program phase, medical students participate in large and small group learning activities as well as clinical learning activities in health care setting.

**Mandatory Sessions**

Educational sessions that are critical to the MD program and the student’s progress are deemed to be mandatory. If missed, mandatory sessions can put the student at a disadvantage within the program and may affect program and national exam results. Many educational sessions have an assessment component within them. Assessment may range from an in-session assignment to written or oral exam/quiz to OSCEs to assessment of clinical skills. Absences from sessions that include assessment are more difficult to accommodate, both because of the impact on the comparability (i.e., fairness) of assessment among students and because of the need to either
reschedule the session or forego the opportunity for assessment (and possibly accepting a grade of zero).

1.1 Non-Mandatory Sessions
Non-mandatory sessions are valuable important components within the curriculum, but are such that absences from them can be relatively easily made up with extra effort on the student's part (i.e. self-directed learning through a lecture or obtaining lecture notes from a colleague). Note that non-mandatory does not mean that the material taught in it will not be assessed.

Scope of this Policy:
This policy applies to all undergraduate students registered in Years 1 and 2 of the Doctor of Medicine (MD) program at the University of Saskatchewan irrespective of the geographically distributed site/campus to which they are currently assigned.

Responsibilities
Pre-clerkship administrative staff and Year Chairs/Year Site Coordinators are responsible for operationalizing the procedures outlined, with oversight by the Program Manager, and consultation as required with the Assistant Dean Academic, and Associate Dean UGME.

Procedures:
1. SESSION TYPES
As general guidance, the program classifies educational sessions into two broad categories: mandatory and non-mandatory.

<table>
<thead>
<tr>
<th>Mandatory</th>
<th>Non-Mandatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation</td>
<td>Lectures or large group sessions/seminars*</td>
</tr>
<tr>
<td>Small group sessions</td>
<td>* unless otherwise specified by the course director and/or the UGME office (e.g. in-class quizzes or assignment). Each course syllabus will provide specific details about the role and timing of in-class assessments.</td>
</tr>
<tr>
<td>o Tutorials, cases, labs, clinical skills*</td>
<td>These sessions are HIGHLY RECOMMENDED for your academic success, but attendance will not be tracked.</td>
</tr>
<tr>
<td>Scheduled assessments (i.e. written and oral exams, presentations, in-class assignments, OSCEs and any other session where student performance is assessed or submissions of work is expected)</td>
<td></td>
</tr>
</tbody>
</table>

*Note that Mandatory sessions are typically scheduled well in advance. Clinical Skills sessions, particularly DSPE sessions, are an exception. To accommodate the clinical schedules of physician preceptors, these sessions may be added or rescheduled up to 48 h in advance with email notification to the student. Therefore students should anticipate and plan for this potential by requesting a planned absence if one is required. If a planned absence has been approved and a mandatory session has been moved to that day, the student will not be penalized professionally or academically.
All other sessions are left to the discretion of the Course Director and/or the UGME office. It must be assumed that sessions not specifically listed are mandatory unless otherwise indicated.

NOTE: Regardless of the nature of the session (mandatory or non-mandatory), students are responsible for knowing the content as listed in the curricular/course objectives. The College of Medicine reserves the right to require students to make up missed time, regardless of the nature of the session, reason for the absence, or whether or not the absence was approved appropriately, to ensure the academic success of students.

Failure to abide by these regulations without appropriate prior approval or notice after the fact for emergent absences, or disregarding the program decision in relation to an absence request, will be deemed as a professionalism concern as outlined in M.D. Program Procedure for Concerns with Medical Student Professional Behaviour.

2. Types of Absences:

It is recognized that there may be circumstances that merit absence from educational activities. In determining these circumstances, the following principles will be considered and respected:

   a. Equity and transparency within the limits of confidentiality.
   b. The ability to fulfill academic responsibilities (those of the student and those of others involved in the educational process).
   c. The well-being of the student, including recognition of and respect for the student’s abilities and limitations
   d. The integrity of all aspects of the M.D. program and those involved in the program (i.e. students, faculty, staff, allied health professionals, etc.).

Notation of all absence requests will be made on the student’s file to track absences, which will inform future absence requests.

In all cases, students in academic difficulty may be denied planned absence requests if it is felt that the absence(s) may further affect their academic performance.

2.1 Planned Absences (including from Mandatory Sessions)

Planned absences are intended to allow students to request time away from mandatory or non-mandatory sessions for important professional or personal reasons.

2.1.1. Limitations on planned absences:

Planned absences may not be requested and will not be approved for Final examination periods (including OSCEs). Absences for final examinations will only be considered for reasons of illness or personal/family emergencies. Please see Deferral Policy.
2.1.2 Types of Planned Absences:
- Observance of a religious/faith holiday
- Health care appointment which cannot be scheduled outside of academic hours
- Attendance at a funeral or memorial service (when date is know in advance)
- Presentation at an academic conference
- Attendance at an academic conference
- Invited and active participation in organized athletics or other competition
- Active participation in a major personal celebration or event (i.e. wedding, baptism, etc.)
- Attendance at a College of Medicine committee meeting
- Appointment with another College of Medicine or University office/leader
- Important professional leadership activities associated with University of SK, College of Medicine and groups affiliated with the College of Medicine
- Other planned and/or foreseeable absences

2.1.3. Process for Applying for Planned Absences:
- Students are advised that they should avoid booking travel until their request is fully approved. Students are responsible for any costs incurred if booked travel must be cancelled.
- The student must submit a request using the Curriculum feedback tool or appropriate form directly (email or in person) to the UGME (site specific) Administrative Coordinator (In Saskatoon this will be the Year Administrative Coordinator and in Regina the Education Consultant, Year 2). This should be done as soon as the student becomes aware of the need for an absence. The guideline is a minimum of 4 weeks in advance of the planned absence.
- As part of the request, supporting documentation may be required. If the supporting documentation is confidential in nature (i.e. medical, or sensitive family matters), documentation can be submitted to the Student Affairs Office at the student’s site. The UGME office will consult with Student Affairs as part of their consideration, without breaching confidentiality.
- The College of Medicine will consider the request and provide a decision in a timely manner. The guideline is within 2 weeks of the request or in advance of the absence, whichever is longer. Note: each site will have a slightly different approval process. This process may include the relevant module or course personnel.
- The Administrative Coordinator will either deny the request, approve the request, or conditionally approve the request.
- Conditional approvals may occur in the setting of a mandatory session, in which the Module or Course Director must be consulted to determine if/how an alternate learning experience or
assessment can be provided. This may include the student requesting a deferral of an assessment (see Deferral Policy). In limited situations, this may include the Administrative Coordinator switching students between groups, with the agreement of both students.

- In the event of a conditional approval, the Administrative Coordinator and/or student will consult with the relevant Preceptor/Module or Course Director to determine if the requested absence can be accommodated.
- The Administrative Coordinator will advise the relevant Module or Course Director and/or Administrative staff member of an approved planned absence.
- In the event that a mandatory learning activity is scheduled for the student after a planned absence has been approved, the student will not be penalized professionally or by a loss of academic marks. However, typically a learning session will not be rescheduled for the student; marks for missed assessments will be addressed through re-weighting or alternate assessment if required as determined by the Module/ Course Director.

2.1.4. Appeals of Planned Absence Request Decisions:
- Relevant Administrative staff (Year Administrative Coordinator or Regina Education Consultant) will approve or deny planned absence requests based on this policy.
- If a student disagrees with Administrative decisions, the student may appeal the decision to the appropriate Year Chair or designate, by providing, in writing (email acceptable) the reasons why the student is appealing the decision. The decision of the Year Chair shall be final. The Student may seek guidance from the Office of Student Affairs in requesting such an appeal.

2.1.5. Guiding Principles/Considerations for Planned Absences: Reason for the absence
- The type and number of session(s) that will be affected, including, type and weight of assessment, and importance to the course/program
- The student’s academic performance to date
- The student’s professional performance to date
- The number of absences to date and/or scheduled/planned
- Note that the UGME program will endeavour to adapt the schedule to accommodate SMSS-identified events of importance to the medical student community

2.1.6. Typical Outcomes in the Case of a Request for a Planned Absence:

Observance of a religious/faith holiday
- Requests will generally be approved, save for extraordinary extenuating circumstances
- The College of Medicine must provide a compelling reason if not approved.
- The College of Medicine will pursue alternative arrangements to enable the student to make up any missed assessments and/or other critically mandatory sessions due to a religious or faith holiday.

Health care appointment
- Requests for an absence from a non-mandatory session will generally be approved
- Requests for an absence from a mandatory session will be dealt with on a case-by-case basis
- Students are requested to make every effort to schedule health care appointments at a time that does not require an absence from educational sessions.

Attendance at a funeral or memorial service
• Requests will generally be approved, save for extraordinary extenuating circumstances
• The College of Medicine will pursue alternative arrangements to enable the student to make up any missed assessments and/or other critically mandatory sessions due to a funeral or memorial service.

Attendance at academic conferences
• Requests for an absence will generally be granted to a maximum of 3 days per academic year
• Request for absences more than the allowable amount will be addressed on a case-by-case basis. Consideration will be given to those who are presenting or are involved in an administrative capacity or organization meetings at a conference
• Requests for an absence from mandatory sessions will be dealt with on a case-by-case basis. Specific considerations include the relative weight of the assessment to be missed, logistics of rescheduling the assessment, impact of foregoing the assessment (i.e., lost opportunity for feedback, a grade of zero, etc.) and student academic performance

Students are required to submit the conference program and, if applicable, confirmation of acceptance of their paper/poster as part of their initial request.

Invited and active participation in an organized athletics or other competition, at the varsity level or equivalent
• Requests for an absence from a non-mandatory session will generally be approved
• Requests for an absence from a mandatory session will be dealt with on a case-by-case basis. Specific considerations include the relative weight of the assessment to be missed, logistics of rescheduling the assessment, impact of foregoing the assessment (i.e., lost opportunity for feedback, a grade of zero, etc.) and student performance.
• Students are required to submit documentation of their official invitation to participate as part of the initial request.

Active participation in a major personal celebration or event (i.e., wedding, baptism, etc.)
• Requests for an absence from non-mandatory sessions will generally be approved to a maximum of 3 days per academic year.
• Requests for an absence from mandatory sessions will be dealt with on a case-by-case basis. Specific considerations include the relative weight of the assessment to be missed, logistics of rescheduling the assessment, impact of foregoing the assessment (i.e., lost opportunity for feedback, a grade of zero, etc.) and student academic performance
• Students are required to provide a description of the event and their participation in the event as part of their initial request.

Attendance at a College of Medicine committee meeting
• Requests for an absence from a non-mandatory session will generally be approved
Requests for an absence from a mandatory session will not be approved other than in exceptional circumstances for meetings in which the student member’s participation is essential and the meeting cannot be scheduled at another time; confirmation from the Chair will be required

Appointment with another College of Medicine or University leader
• Requests for an absence from a non-mandatory session will generally be approved
• Requests for an absence from a mandatory session will not be approved other than in exceptional circumstances for an appointment in which the student member’s participation is
essential and the appointment cannot be scheduled at another time; confirmation from the Leader will be required
• Students are requested to schedule these appointments outside of curriculum time to the greatest extent possible
• College leaders are asked to be cognizant of the students’ academic program when requesting appointments

**Vacation**
• Vacation requests during pre-clerkship will **not be approved** as planned absences.

**Other PLANNED absences**
• Requests will be considered on a case-by-case basis.
• Note that the UGME program will endeavour to adapt the schedule to accommodate SMSS-identified events of importance to the medical student community

**2.2 Flex Days**

Flex days are intended to allow students, as adult learners, the option of taking a planned absence without the need to provide a reason or documentation in support of that absence.

Flex days may be used for absences from non-mandatory sessions and some specific types of mandatory sessions.

**2.2.1. Limitations on Flex Days:**

A student may request a **maximum of 3** Flex Days per academic year.

Flex days may not be requested and will **not be approved** for the following:
• Year or course orientations
• Clinical Skills sessions
• iPBL sessions
• quizzes, team based learning sessions (TBLs), mid-term or end-of-module exams
• Final exams (including OSCEs)

Flex days may be requested and will **be considered** for the following:
• small group case-based seminars or learning sessions (such as small groups in Foundations or Clinical Integration courses)*
• module orientations**
*there may be exceptions which will be identified to students as not eligible for Flex Days
**students are responsible for familiarizing themselves with information covered in the module orientation, even if absent

**2.2.2. Process for Applying for Flex Day Absences:**
• Students are advised that they should **avoid booking travel until their request is fully approved**. Students are responsible for any costs incurred if booked travel must be cancelled.
• The student must submit a request to the UGME (site specific) Year Administrative Coordinator, using the appropriate form, as soon as the student becomes aware of the need for an absence, at a minimum 1 week in advance of the planned absence. Flex Days will not be retroactively approved.

• The College of Medicine will consider the request and provide a decision in a timely manner, ideally by 3 days prior to the requested absence. Note: each site will have a slightly different approval process. This process may include the relevant module or course personnel.

• The Administrative Coordinator will either deny the request, approve the request, or conditionally approve the request.

• Conditional approvals may occur in the setting of a mandatory session, in which the Module or Course Director must be consulted to determine if/how an alternate learning experience or assessment can be provided. In the event of a conditional approval, the Administrative Coordinator and/or student will consult with the relevant Preceptor/Module or Course Director to determine if the requested absence can be accommodated.

• The Administrative Coordinator will advise the relevant Module or Course Director and/or Administrative staff member of an approved Flex Day absence.

• In the event that a mandatory learning activity is scheduled for the student after a Flex Day absence has been approved, the student will not be penalized professionally or by a loss of academic marks. However, typically a learning session will not be rescheduled for the student; marks for missed assessments will be addressed through re-weighting or alternate assessment if required as determined by the Module/ Course Director.

• If an assessment (such as an in-class or out-of-class assignment) occurs on a day that a Flex Day has been approved, the student is still responsible for completing the assignment by or before the stipulated due date, and reviewing the content missed. For assessments that cannot be done without attendance, a student should anticipate receiving a potential zero on that assessment.

• Flex Days are on a first-come, first-serve basis and requests will be declined if > 20% of a small group or > 20% of the class for a large group session would be away on Flex Days on a given day.

2.2.3. Appeals of Flex Day Request Decisions:
• Relevant Administrative staff (site-specific Year Administrative Coordinators) will approve or deny planned absence requests based on this policy

• If a student disagrees with the Administrative decision, the student may appeal that decision to the appropriate Year Chair or designate, by providing, in writing (email acceptable) the reasons why the student is appealing the decision. The decision of the Year Chair shall be final for appeals of Flex Day decisions. The Student may seek guidance from the Office of Student Affairs in requesting such an appeal.

2.3 Unplanned Absences

2.3.1. Types of Unplanned Absences:
• Illness and/or injury
• Serious situation with a family member or other loved one
• Personal crisis
• Transportation problems
• Other reasons
2.3.2. Process for notification for Unplanned Absences:

- In all cases, the students should ensure the personal well-being and immediate safety of themselves and others affected within the situation.
- Student must notify the UGME office (site specific) as soon as the student is able to do so after attending to the emergent needs/issues. If a student is ill, the student should make every effort to advise the office in advance of the absence if possible. This is particularly important for mandatory sessions and assessments.
- Medical or other documentation of the need for the absence may be required. The UGME office will advise the student if any other documentation is required. If the supporting documentation is confidential in nature (i.e. medical, or sensitive family matters), documentation can be submitted to the Student Affairs Office at the student’s educational site.
- The UGME office will work with the student to reschedule any mandatory assessed sessions that may have been missed due to the unplanned absence as appropriate.

2.3.3. Guiding Principles/Considerations for Unplanned Absences:

- Acknowledgement that unforeseen and emergent circumstances arise and that the student has the right to determine how best to deal with such circumstances, including being absent from educational sessions.
- Students must notify a staff or faculty member within the College of Medicine, or the Office of Student Affairs within a reasonable timeframe surrounding the unplanned absence. Failure to notify is unacceptable and the College may not be obligated to provide make-up sessions or assessments.
- Acknowledgement and respect of the supportive and compassionate environment that the College endeavours to provide to all individuals.
- Understanding that any absence may have consequences and create added responsibility as it relates to the student’s medical education.
- Given that all courses will continue during an absence, the volume of material and the number of clinical skills sessions that are missed must be considered in the plans for return to classes after absence. If a student misses more than 3 weeks of school, the Year Chair will work with the Assistant Dean Academics and Student Affairs/ Associate Dean to determine the appropriate course of action, which may include recommendation of withdrawal from the current academic year and re-entry into the following academic year.
- For unplanned absences greater than 1 week (whether continuous or cumulative), the Year Chair in consultation with the Assistant Deans Academic and Student Affairs/ Associate Dean will determine the appropriate course of action. Student Affairs representatives will assist with planning for either a withdrawal or return to program after an extended absence.

Illness and/or injury:

- Once able, the student should contact the UGME office and indicate the absence was due to illness or injury.
- Additional documentation may be required depending on the nature of the missed session(s), scheduled assessment (if any), the duration of the absence and history of past absences.
- Arrangements will be made to ensure the student is able to make up missed sessions and/or assessments at a later date which may include alternative formats.
Serious situation involving a family member or other loved one
- Once able, the student must contact the site specific UGME or Student Affairs office and indicate the absence was due to a personal problem affecting a family member and/or loved one
- Additional documentation may be required depending on the nature of the missed session(s), scheduled assessment (if any), the duration of the absence and history of past absences
- Arrangements will be made to ensure the student is able to make up missed sessions and/or assessments at a later date which may include alternative formats

Personal crisis
- Once able, the student must contact the site specific Student Affairs office and indicate the absence is due to a personal crisis
- Student Affairs will work with the student and the UGME office to determine the appropriate course of action
- Arrangements will be made to ensure the student is able to make up missed sessions and/or assessments at a later date which may include alternative formats

Transportation problems
- The student must contact the UGME office as soon as possible once it is apparent that an absence is likely to result from the delay.
- Supporting information and documentation must be provided, which includes the nature of or reason for the travel delay
- When possible, arrangements will be made to ensure the student is able to make up missed sessions and/or assessments at a later date which may include alternative formats
- Arrangements and accommodations will NOT be made for absences that result in the poor planning on the part of the student

Other reasons
- Other unplanned absences will be dealt with on a case-by-case basis

3. TOTAL ABSENCES
3.1. Guiding Principles:
- Significant absences may impact a student’s learning, and the program reserves the right to limit absences in order to best support learning.
- Processing absence requests requires significant administrative resources and reasonable limits are required in order to allow Administrative Coordinators to attend to other important responsibilities.

3.2. Process:
- All absences will be tracked by the relevant UGME Administrative staff.
- A student may be allowed a maximum of 5 approved absences (combined Planned and Flex Day absences) per academic year. Exceptions may be made to the 5 maximum days for planned absences due to leadership activities for students in good academic standing. Please see Student Leadership Absence Policy.
- Students in academic difficulty may have their application for approved absences declined if there is concern that additional absences may put the student at further
academic risk, regardless of number of approved absences used to date. This limitation would be only applied in consultation with the student and the Year Chair.

- Students who have unplanned absences due to illness or personal circumstances and who subsequently apply for Planned or Flex Day absences which would result in an excess of 5 total absences per year, may have Planned or Flex Day absences declined. This will depend on academic performance, the relative importance of the activity for which the student is requesting an absence, and potential impact of the individual and cumulative absences on learning and assessment. The Year Chair will be consulted on this decision.

**Contact:**

Assistant Dean Academic, UGME
Appendix I.2 CoM MD Program Clerkship Attendance and Absence Policy Overview

MD Program Clerkship Attendance and Absence Policy Overview

Responsibility: Assistant Dean Academic

Approval: Student Academic Management Committee

Approved: Student Academic Management Committee, May 2016
Revised: Student Academic Management Committee, May 9, 2017
Revised: Student Academic Management Committee, Aug 3 2017
Revised: Student Academic Management Committee, June 5 2018
Revised: Student Academic Management Committee, May 9 2019

Date:

Purpose:

The purpose of this policy is to provide clear and consistent expectations for students, staff and faculty related to student attendance in the clerkship portion of the MD program.

Other related documents are the Student Leadership Absence Policy, Pre-Clerkship Attendance and Absence Policy, and Procedure for Procedure for Session Attendance Across Sites/ Campuses.

Principles:

Active participation by medical students in learning opportunities is critical to their formation, education, and training. Sustained and deep engagement, which requires regular and punctual attendance, is expected of all students in all of their classes (lectures, laboratories, seminars, tutorials, small groups and clinical sessions). Students who neglect their academic
responsibilities may have academic consequences and this behaviour will also be addressed through the Procedures for Concerns with Medical Student Professional Behaviour.

The College of Medicine recognizes that medical students are adult learners and entitled to the privileges and responsibilities that come with such status. That being said, for many components of the program, the College of Medicine relies heavily upon faculty with clinical obligations, their patients and other patient volunteers. Absenteeism and lack of punctuality by students place an unwelcome strain on the goodwill of all concerned. Often a significant degree of accommodation has occurred to make these educational experiences possible. Replicating these experiences to accommodate student absences is extremely difficult. Acceptance of responsibility for attendance and participation in patient care is part of the student’s professional education and responsibility. Appropriate attendance and punctuality are indicative of the student’s understanding of, and adherence to, expectations of professional behaviour.

It has been the College’s experience that, for some students, chronic non-attendance often ends up in academic and/or professional difficulty. Students also end up feeling disengaged and separated from their class cohort, which can further affect academic success because of a lack of peer support. The College reserves the right to mandate attendance by those students who are in academic or professional difficulty. Such circumstances would be clearly documented and provided in writing to the student.

**Definitions:**

*Clerkship:* The third to fifth years of the University of Saskatchewan Undergraduate Medical Education Program (UGME) are termed “Clerkship”. During this program phase, medical students participate in large and small group learning activities, with a focus on clinical learning activities in health care setting.

*Mandatory Sessions* - ALL activities in clerkship are considered mandatory unless otherwise expressly indicated by the Course Director or most responsible preceptor.

**Scope of this Policy:**

This policy applies to all undergraduate students registered in Years 3-5 of the Doctor of Medicine (MD) program at the University of Saskatchewan irrespective of the geographically distributed site/campus to which they are currently assigned.
Responsibilities

Clerkship administrative staff and Year Chairs/ Year Site Coordinators are responsible for operationalizing the procedures outlined, with oversight by the Program Manager, and consultation as required with the Assistant Dean Academic, and Associate Dean UGME.

Procedures:

1. SESSION TYPES

- Orientation
- Clinical activities
- Site-specific didactic teaching
- Rotation-specific didactic teaching
- Selected Topics in Medicine and Preparation for Residency courses (except during rural rotations without videoconferencing capacity)
- Scheduled assessments (i.e. written and oral exams, presentations, OSCEs and any other session where assessment of performance is expected)

NOTE: Regardless of the nature of the session, students are responsible for knowing the content as listed in the curricular/course objectives. The College of Medicine reserves the right to require students to make up missed time, regardless of the nature of the session, reason for the absence, or whether or not the absence was approved appropriately, to ensure the academic success of students.

Failure to abide by these regulations without appropriate prior approval or notice after the fact for emergent absences may be deemed as unprofessional conduct as outlined in MD Program Procedures for Concerns with Medical Student Professional Behaviour. If a student disregards the decision of the College of Medicine or other authority in relation to the absences, this may also be considered unprofessional conduct.

Unexplained absences may be reflected in the final grade and may constitute grounds for failure of the rotation or course, even if the composite grade for other aspects of the assessment exceeds the passing grade. The UGME office must be notified of any prolonged or unexpected absences – please see the Leave of Absence Policy.

If a student misses less than the maximum time permitted but there is concern that they had inadequate experience to perform well on assessments, they may be requested to do additional time in the rotation prior to assessments.
2. Types of Absences:

Please note: The *maximum* amount of time away from a rotation for any reason is 5 days.* This may even be less depending on the rotation. Please see the Core Clinical Rotation Syllabus for details.

2.1 Sick Leave

Students who are acutely ill may be required to miss clinical learning activities, both for their own well-being and the well-being of patients. Illness can include both physical illness and mental health issues. If a student is ill and unable to fulfill his or her clinical duties, as identified by the student or supervising resident or preceptor, the student must do ALL of the following:

1. Notify the UGME office administrator at his or her site (See Appendix A for current list), and:
   a. If a contact is away from the phone, leave a message and/or send an email.
   b. Notify the administrative assistant in the department of his or her current rotation (See Clerkship Student Information Guide or College of Medicine website for contacts).
   c. Notify hospital switchboard.
   d. Notify his or her preceptor or ward attending.
   e. Notify the residents with whom the student is working.

If a student becomes ill while on duty the student must:

1. Notify his or her preceptor and resident as soon as possible to ensure all of his or her duties are transferred to others.
2. Notify everyone listed above.

If a student becomes ill while on call the student must:

1. Notify everyone listed above.
2. Try to find a replacement for call (ideally by switching with another student if possible. If switching call with another student is not possible, the student will be scheduled to make-up the call)

Notify the attending for the case room if on Labour and Delivery.

The student must make this notification as soon as possible after attending to the emergent needs/issues. The student should make every effort to advise the office in advance of the absence if possible, for both classroom sessions as well as clinical activities.

If a student must be absent due to an urgent medical or dental appointment, the student must notify the UGME office administrator at his or her site (see Appendix A for current list), and:

a. If a contact is away from the phone, leave a message and/or send an email.
b. Notify the administrative assistant in the department of his or her current rotation (See Clerkship Student Information Guide or College of Medicine website for contacts).
c. Notify hospital switchboard.
d. Notify his or her preceptor or ward attending.
e. Notify the residents with whom the student is working.

Note: Non-Urgent health care appointments should be booked during holiday time, outside of normal work hours. When these cannot be booked outside of normal work hours, please utilize Medical Leave process below (2.2). An application for absence form should be submitted for tracking purposes.

*If a student has already taken the 5 day maximum from a rotation for holidays and/or education leave, and subsequently requires additional time away for the rotation due to illness, the student may be required to make up learning time after the scheduled rotation end date. This will be determined by the Rotation Coordinator. If a student disagrees with a Rotation Coordinator decision related to additional time on rotation, the student may appeal the decision to the Year Chair, whose decision is final.

Extended illness may require a formal medical leave request, with documentation (see below). Documentation will typically be requested for health-related absences of more than 3 days.

* Please note: Although the maximum time away from a rotation may be 3-5 days (depending on the rotation), if a student is absent due to illness more than 8 days over the course of Year 3, this will prompt a meeting with the Year Chair or designate as well as another rotation director/coordinator and the Office of Student Affairs. This may result in courses being considered incomplete. For Year 4, if a student is absent due to illness more than 5 days over the course of the year, the same process will be followed.

2.2 Medical/Personal/Parental Leave

Leaves may be requested for significant health or personal issues. For medical/personal/parental leaves of one week or less, or for absence for a scheduled health care appointment, which cannot be scheduled outside of normal work hours, permission for medical leave should be sought from the Rotation Coordinator in consultation with the Year Chair, and an application for absence form submitted for tracking purposes. Students are encouraged to also seek support from the Office of Student Affairs. The student’s file will be reviewed to determine if the student is in academic difficulty. A decision to deny brief medical leave by a Rotation Coordinator/Year Chair may be appealed to the Assistant Dean Academic, whose decision is final.

Action/Documentation required for brief leaves of one week or less:

1. The student should contact Student Affairs at his or her site to discuss the reason for the leave request.
2. A leave request form Application for Absence form should be submitted.
3. A letter of support for the leave from the student’s own health care provider should be provided. The UGME office will work with the student to determine if any other documentation is required. If the supporting documentation is confidential in nature documentation can be submitted to the Student Affairs Office at the student’s educational site, who will confirm its receipt to the UGME office.

4. Re-entry to the program may need approval from SAMC depending on the duration of medical leave.

For prolonged medical/personal/parental leaves (greater than one week), please refer to the MD Program Leave of Absence Policy. Permission for prolonged medical leave should be sought from the Assistant Dean Academic, who will consider the leave request in consultation with the Rotation Coordinator(s), Year Chair and the Office of Student Affairs.

2.3 Compassionate Leave

Compassionate leave can be taken for reasons of death of a person close to the student or for significant family emergencies requiring the student’s attention. Permission for compassionate leave must be sought from the Rotation Coordinator affected by the absence. The Coordinator will consult with the UGME office regarding the leave and documentation may be required. These requests will be dealt with on a case by case basis. Under regular circumstances compassionate leave will not exceed 3 days.

*If a student has already taken the 5 day maximum from a rotation for holidays and/or education leave and/or illness, and subsequently requires additional time away for the rotation for compassionate leave, the student may be required to make up learning time after the scheduled rotation end date. This will be determined by the Rotation Coordinator. If a student disagrees with a Rotation Coordinator decision related to additional time on rotation, the student may appeal the decision to the Year Chair, whose decision is final.

Extended leaves for personal or compassionate reasons may be accommodated. Students are encouraged to work with the Office of Student Affairs if considering a leave request. See Leave of Absence Policy.

2.4 Educational Leave

The following policy should be used to allow students to attend educational activities (e.g. conferences):

- A maximum of 4 days in Year 3 is allotted for Educational Leave. A maximum of 3 days in Year 4 is allotted for Educational Leave. Year 3 Education Leave may be carried over to Year 4, however students should be aware that the hosting institution may decline the request for educational Leave during an approved elective. Year 4 Education Leave may also be used during Year 3 with permission of the relevant Rotation Coordinator and Year Chair.
• It is expected that students presenting at a conference will use their Educational Leave to attend. However, in the exceptional circumstance that a student is invited to present at a conference after using maximum Educational Leave, additional time may be granted by the Rotation Coordinator and Year Chair to attend.
• Education leave will not be granted during the week of an OSCE.

Apart from these timing considerations, standards for successful completion of rotations will not be amended.

• To avoid confusion or misunderstanding, students should make their arrangements directly with the relevant Rotation Coordinators.
• A request for Educational Leave must be documented on an Application for Absence form and approved by the Rotation coordinator and forwarded to the UGME Administrator. This will be tracked in the UGME office and the leave request will be declined if the 7 day maximum is exceeded.
• If a student disagrees with the decision of a Rotation Coordinator to decline an Education Leave request, the student may appeal that decision to the Year Chair. The decision of the Year Chair is final.

2.5 Vacation

Vacation allocation is 8 weeks (40 days), excluding weekends, throughout clerkship: 5 weeks in Year 3 (of which 2 will be scheduled in December) and 3 weeks in Year 4 (of which 2 will be scheduled in December). A maximum of one week from Year 3 may be carried over to Year 4. Students may use a portion of their holiday time for electives (typically in Year 3) — usually students who are interested in highly competitive programs where additional elective time would be of benefit — see Elective policy.

Note that the December holidays will be scheduled for Clerks, and other holidays will be scheduled at the individual Clerk’s request (see parameters below).

• A combined maximum of 5 week days may be taken as vacation and/or education leave during a 6 week block.
• A maximum of 3 week days may be taken as vacation during a 4-week block (Rural Family Medicine, Emergency Medicine)
• No vacation time/education time is allowed during a 2-week block (Anesthesia, Selectives)
• Vacation leave will be arranged such that any instance in which 5 regular working days are taken consecutively, the student will be taken off call the weekend before OR after the requested weekdays.
• Vacation leave is not allowed during the week of the OSCEs and the last week of a rotation when an NBME is to be written.
• “Off call” days do not count as vacation days and are subject to approval by the department.
• Students shall request vacation time from the Clerkship Administrative Assistant of the department in which the student intends to take that time at least 6 weeks in advance of starting service in that department.
• Additionally, some rotations will not allow students to take time off the first week of the rotation as that is when departmental orientations are scheduled.
• A request for Educational Leave must be documented on an Application for Absence form, submitted to the Departmental Clerkship Administrative Assistant and approved by the Rotation Coordinator then forwarded to the UGME Administrator. This will be tracked in the UGME office and the leave request will be declined if the vacation and/or education day maximum is exceeded.
• Please note that vacation time must be approved first prior to arranging extra electives, which must also be approved (see electives policy).

2.6 Flex Days

Flex days are intended to allow Year 3 students the option of taking a planned absence without the need to provide a reason or documentation in support of that absence. Students may take Flex Days to proactively support their mental and physical health, if they recognize they are experiencing symptoms of burn-out, and/or to address circumstances that may arise on short notice (such as appointments or family issues) such that scheduling vacation is not an option. Flex Days are consistent with the definition of “personal days” as defined by the Canadian Federation of Medical Students (CFMS 2017. Personal Day Policies at Canadian Medical Schools position paper).

Flex Days do not apply to Year 4 students, due to challenges applying this policy during electives including out-of-province electives. Students requiring urgent time off during electives should request this directly of their electives supervisor, and should notify the University of Saskatchewan UGME office. In addition, the student may request support from their Year 4 Chair and Office of Student Affairs as needed.

• Undergraduate Year 3 clerkship medical students shall be allowed to convert a maximum of 2 days during the academic year of their vacation time to Flex Days.
• No rationale for the absence needs to be provided for a Flex Day absence.
• A minimum of 3 business days’ notice is required in advance of the requested Flex Day, to allow notification of preceptors and schedule adjustments if required.
• Absences due to Flex Days will count towards the maximum amount of time away from a rotation (Varies by rotation please see the Core Clinical Rotation Syllabus for details). If absences exceed the maximum amount of time away for the rotation students will be required to make up extra time under the discretion of the rotation director.
• Students will be able to use a maximum of 1 Flex Day per 6-week rotation up to the maximum of 2 per academic year. There is no scheduled holiday time during the selective clinical rotation and students will not be allowed to use Flex Days during this rotation.
• A Flex day counts as a full day (ie. Cannot be requested as a half day).
• Flex days are not to be used during orientation sessions, the week of an OSCE, the day of an oral examination/presentation, or the last week of a rotation when an NBME/final rotation examination is to be written.
• Flex days are not to be used when a student is on call unless arrangements have been made ahead of time to ensure coverage and appropriate staff/faculty have been advised of the call change.

• Flex days may be taken during the Selected Topics Course. The student is still responsible for material taught during the session, and any assessments missed will must either be made up or the assessments re-weighted, as determined by the Course Director. Flex Days may not be taken on a day that the student is responsible for presenting in the course.

• Student must complete an Application for Absence for the Flex Day absence. In addition, students are required to notify the following contacts about the absence as soon as they are able:
  a. Notify the UGME office administrator at his or her current site.
  b. Notify the administrative assistant in his or her current rotation
  c. Notify hospital switchboard
  d. Notify his or her preceptor or ward attending
  e. Notify the residents with whom the student is working with.

### 2.7 Statutory Holidays

Students are entitled to all statutory holidays. Clerks who are on duty on a statutory holiday between 0800 and 2300 shall be given time off in lieu of that day. Time off in lieu must be arranged with and approved by the departmental Clerkship Administrative Assistant of the rotation in which the time was earned.

Statutory holidays for Clerks include:

• New Year’s Day
• Family Day
• Good Friday
• * Easter Monday
• Victoria Day
• Canada Day
• Saskatchewan Day
• Labour Day
• Thanksgiving Day
• Remembrance Day
• Christmas Day
• Boxing Day

*Please note that even though Easter Monday is not considered a statutory holiday by the University of Saskatchewan, clerks are still entitled to a day in lieu if they work this day.

If the statutory holiday falls over a weekend, the day in lieu will be for the day observed by the University of Saskatchewan only.
3. TOTAL ABSENCES

3.1. Guiding Principles:

- Significant absences may impact a student’s learning, and the program reserves the right to limit absences in order to best support learning.
- Processing absence requests requires significant administrative resources and reasonable limits are required in order to allow Administrative Coordinators to attend to other important responsibilities.

3.2. Process:

- All absences will be tracked by the relevant UGME Administrative staff.
- Absences are limited by the parameters outlined in the previous sections of this policy. As noted, the maximum amount of time away from a rotation for any reason is 5 days.* This may even be less depending on the rotation. Please see the Core Clinical Rotation Syllabus for details.
- Exceptions may be made to the maximum number of days absent per rotation due to leadership activities for students in good academic standing, if the Rotation Coordinator is confident that adequate clinical exposure can still be achieved on the rotation. Please see Student Leadership Absence Policy.
- Students in academic difficulty may have their application for approved absences declined if there is concern that additional absences may put the student at further academic risk, regardless of number of approved absences used to date. This limitation would be only applied in consultation with the student and the Year Chair.
- Students who have unplanned absences due to sickness or personal circumstances and who subsequently apply for Planned or Flex Day absences which would result in an excess of the maximum number of days absent per rotation should anticipate that further absences requests will be declined. Exceptions may be considered depending on on academic performance, the relative importance of the activity for which the student is requesting an absence, and potential impact of the individual and cumulative absences on learning and assessment. The Year Chair will be consulted on this decision.
- In addition to maximum absences per rotation, if a student is absent due to illness more than 8 days over the course of Year 3, this will prompt a meeting with the Year Chair or designate as well as another rotation director/coordinator and the Office of Student Affairs. This may result in courses being considered incomplete. For Year 4, if a student is absent due to illness more than 5 days over the course of the year, the same process will be followed.

Contact:

Assistant Dean Academic, UGME