

Pathways to “Involved Professionalism”: Making Processes of Professional Acculturation Intentional and Transparent

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Abstract- Context - An increase in managerialism and a decrease in trust of the professions have challenged traditional concepts of professionalism. The market model of professionalism espoused by some critics also poses problems for professions, professionals and recipients of professional services. Professional development is now an important component of medical curricula. We believe professionalism is evolving and suggest a concept of involved professionalism as a framework for understanding the complex relationships between professional practice, community and responsibility.

Purpose - The purpose of this article is to unpack and compare varying concepts of professionalism, and examine how these concepts can impact on the health care professions and on professional acculturation of new recruits on entry to their medical work environment.

Summary - In a changing socio-political climate, traditional notions of professionalism have met criticism in that the autonomy of a profession can disempower the consumers of its service. In New Zealand and elsewhere, market reformers have introduced business oriented decision making structures accompanied by the rhetoric of consumer choice. This shift has constrained the professional decision making ability of medical professionals.

Conclusion - We suggest that a further model of professionalism is required to address the challenges of the need for community responsiveness, collaboration, high quality health care and a hospitable professional environment. 'Involved professionalism' ties together knowledge, individual responsibility, collective responsibility and responsiveness to society. It is offered as a framework for health practitioners, policy makers and medical educators.

Professionalism and the roles of professionals are being threatened. An increase in managerialism and a decrease in trust of the professions have challenged traditional concepts. Professional development is now an important component of medical curricula. We believe professionalism is evolving and suggest a concept of involved professionalism as the next framework.

The president of the Australasian and New Zealand Association for Medical Education¹ raised the issue of the organization's possible role in publicly engaging in political debate concerning medical education, advocating for high quality and 'educational veracity' in the face of predominant market driven discourses. By engaging in these kinds of activities, teachers of medical students are modeling aspects of 'involved professionalism', the features of

which we shall discuss throughout this paper, and become active participants in the co-construction of a responsive, responsible and knowledgeable profession.

Mark Olssen² has recently published a monograph on the impact of the neo-liberal shift since 1984 on not only universities and academics in Aotearoa/New Zealand, but more broadly on the concept of professionalism. We believe that it is in the interests of the medical profession to move beyond the paradigm of neo-liberal individualism and 'new managerial' practices to find different ways of conceptualizing professionalism that meet the multiple and complex demands faced in contemporary medical practice. This paper represents an invitation to engage and extend current dialog that has arisen around the issues of professionalism, as well as outline our emergent re-

search interests in this area.

Professional development education is seen as an increasingly important curriculum issue for medical schools internationally.^{3,5} While the focus for us at our School of Medicine is often on practical matters of “how to deliver” professional education, we are also becoming concerned with how social and political factors are impacting on the professional life for which undergraduates are being prepared. Wider social issues play a defining role in the development and delivery of professional practice.

Models of professionalism

Professional decision making, across many spheres of professional activity in Aotearoa/New Zealand, has become constrained by market oriented modes of operation. Much professional activity is now framed within contractual arrangements based on measurable market objectives. Educational decisions are now often made on the basis of administrative and marketing needs in maximizing funding, as opposed to any educational rationale. Similarly, decisions about the provision of healthcare are likely to be taken along business lines, with less reference to priorities determined by health professionals themselves. Olssen² considers this is inconsistent with a traditional notion of professionalism. He says:

“Professionalism conveys the idea of a subject directed power based upon the liberal conceptions of rights, freedom and autonomy. It conveys the idea of a power given to the subject, and of the subject’s ability to make decisions in the workplace. No professional, whether doctor, lawyer or teacher, has traditionally wanted to have the terms of their practice and conduct dictated by anyone else but their peers, or determined by groups or structural levers that are outside of their control.”

More recently this traditional understanding of professionalism has been overturned by the practices of ‘New Managerialism’⁶, which is a term representing a market model of organization within which professional practice is measured through mechanisms of external accountability; professional standards, performance indicators and productivity. Policy makers in our country, in endorsing this model, argued that state provision of services such as health and education had been captured by the providers of the ser-

vices who had their own self-interested agendas.⁷ From such a position, market reformers might consider they represented consumer interests when incorporating business oriented decision making structures within professional domains. The outcome of new managerial practices applied to professional practice has resulted in a ‘new professionalism’ where professionals become implementers of policies decided elsewhere. This position is in opposition to traditional notions of professionalism, such as that described by Olssen², which can potentially protect professionals against the best interests of consumers.

Implicit within the market model is the assumption that consumers are sufficiently well-informed and powerful to make choices in their own best interests about consumption of professional services. Not only do consumers have unequal capacities to make these types of decisions, this model also undermines the importance of professional knowledge contributing to choices and processes of service delivery and distribution. However, Olssen’s definition of the all-powerful, autonomous professional also seems inconsistent with the need for working collaboratively with communities to achieve democratic provision of patient centered health care services

For educators of future professionals, it is important to continue to engage in discourses contributing to the future shape of professional culture. It seems a new version of ‘professionalism’ to the two presented here is needed. This version needs to address problems of power imbalance, and insufficient accountability and responsiveness to the community. At the same time, it needs to incorporate professional knowledge and involvement in the establishment and ongoing development of frameworks for practice and consultation.

The “Involved Professional”

Wilkinson and Harris’s recent work identifies characteristics of final year medical students for whom there was concern about their readiness for professional entry, through in-depth interviews with their clinical supervisors.⁸ They describe the final year as one which is critical to these students making the transition from being a student to taking on a professional role. The emphasis shifts from a focus on acquisition of sound basic knowledge and competence in specific clinical skills as medical students and onto the emerging doctors’ professional performance in the clinical team environment. Consistent with this change in emphasis, Wilkinson and Harris

considered that those students considered most successful by their teachers were those willing to involve themselves fully within the clinical team and in professional activities. Their research suggests that there are certain characteristics and attitudes relating to ‘involvedness’ that are valued as professionalism. The challenge for undergraduate medical education is to develop a clearer understanding of how these characteristics inform successful practice within professional milieu and use this understanding to develop a more transparent and useful professional development program for students to attain this level of engagement.

In our conceptualization of professional development we have centered our dialogue on the notion of ‘involvedness’. The ‘involved professional’ is able to participate in shaping the dynamic professional culture in which s/he is engaged, informed by professional knowledge which policy makers and managers may not possess. S/he is aware of the need to work collaboratively with the communities served by the profession. S/he is responsive to community needs and takes responsibility for socially sensitive and ethical practice on the part of professionals and professional bodies. Thoughtful professionals draw on their knowledge and experience to make judgments in complex situations. They draw on the collective skills and knowledge of their communities and take responsibility for the ongoing education and professional development of themselves and others. They seek out and trial theoretical rationales to make sense of their context and experience. They do this not simply as individual professionals but as part of a professional learning community.

The model of involved professionalism prioritizes the sociality of decision-making, knowledge and learning for professional development. Professional development can be understood as the outcome of engagements in social situations, whether these are in the environment of professional practice, within professional learning communities or interactions between professional and other communities. Learning to become an involved professional requires recognition of the embedded or situated nature of learning. Jean Lave⁹ identifies situated learning as the following:

“Knowledgeability is routinely in a state of change rather than stasis, in the medium of socially, culturally, and historically ongoing systems of activity, involving people who are related in multiple and

heterogeneous ways, whose social locations, interests, reasons, and subjective possibilities are different, and who improvise struggles in situated ways with each other over the value of particular definitions of the situation, in both immediate and comprehensive terms, and for whom the production of failure is as much a part of routine collective activity as the production of average, ordinary knowledgeability”

The notion of situated learning alludes to some of the complexity inherent in becoming knowledgeable. For the professional practitioner, knowledgeability is measured through the application of knowledge in the unpredictable and intricate context of practice. Involved professionalism takes into account the immediate reality of a professional, which is complex in itself, but cannot exclude the possibilities and relevance of research, professionally defined standards and formal development programs to effective professional decision-making. These are all products and tools embodied in the context of a professional culture and understanding - in fact, a thoughtful practitioner may use these tools when engaging in critical reflection and collaborative inquiry. How rich their experience of them has been will reflect on how successfully they are able to make use of them. Professional decision making is a creative process that requires subtlety, flexibility and responsiveness. The complexity inherent in decision-making demands a rich and deep understanding of the products and processes of professional knowledge and how they are invested in professional practice. Table 1 compares this model with the traditional and market models of professionalism.

Wilkinson and Harris discovered that failure to become fully involved with the clinical team was a key indicator for students whose supervisors felt that there were general concerns regarding their performance.⁸ They suggested that a number of personal qualities appeared to influence performance in this respect, and these included poor motivation, rigidity and poor interpersonal skills. Clearly these attributes will be critical for the emergent involved professionals. The following list of objectives represents our conception of how a notion of involved professionalism may impact on the types of curriculum decisions we make in undergraduate medical education. However, as we have presented the notion of professionalism as embedded within the whole professional mi-

Table 1
Characteristics of Different Models of Professionalism

	Traditional Professionalism	New Professionalism	Involved Professionalism
View of learning:	Learning is an individual process	Learning is an individual process.	Learning is a social process.
Professional activity:	Decision making about the nature of professional activity belongs in the hands of professionals.	Professional activity needs to be organized by professional managers.	Professional activity is a set of relationships between self (professionals) and others (other stakeholders) and the products of professional practice (i.e., research/theory). This makes up the context of professional practice.
Quality measures:	Quality is determined by professional knowledge.	Competency can be measured through performance criteria.	Quality through professional development by intentional engagement and dialogue with the social, historical and ethical context of professional practice.
Organization:	Professions organized according to their own disciplinary structures.	Increased specialization and fragmentation sees professions organized by generic structures.	Professions organized according to their own disciplinary structures, however open to influence from stakeholders and through dialog with related disciplines.

lieu, they may also have implications for more general professional development.

- Learning to learn with others and to see learning as a multi-disciplinary and social activity.
- Learning to form and maintain effective professional relationships across disciplines.
- Developing a professional self-concept and identification with professional communities.
- Developing willingness to collaborate and consult and make oneself aware of the needs of communities.
- Develop ability and willingness to engage with professional knowledge products.
- Develop ability and willingness to share responsibility for developing professional context/structures.
- Develop social/ethical sensitivity/consciousness.

We believe these practices have some compatibility with those recommended by Wear and Castellani who promoted incorporating interdisciplinary understandings and the development of a sociologic consciousness in medical professional development.³ Education that fosters an involved professional identity will require a deliberate permeability to the ideas and under-

standings of other disciplines, recognizing the social construction of practice and policy, as well the development of commitment to a professional community.

The influence of predominant market philosophies affecting the developing discipline of professional development education may be leading us to an individualistic approach to professional development. It is important that we think critically about not only whether this approach is most effective, but also about whether it is consistent with the version of professionalism we believe is most beneficial and which we should strive for. Often though, it is presented as the only way of doing things because of the hegemonic nature of the managerial market model itself. The rationality underlying new managerial practices excludes many of what some may argue are legitimate and valuable human functions; e.g. emotion, ambiguity, cultural variance.

Current theories of cognition suggest that intelligence is not embedded in the consciousness of a single individual, but is actually embodied in our social relationships and contexts of activity. Application of theories such as situated cognition⁹ and distributed cognition¹⁰, where intelligence is located in the interaction between selves, others, products and settings, would not differentiate between the personal and social development of professional practice. Overemphasizing an in-

dividualistic approach to professional reflection (i.e. the reflective practitioner) dismisses the significance a practicing professional has on the lives of others, whether it is the effects s/he has on patients, medical students or her/his professional colleagues and superiors. Any development within an individual has some bearing on the development of the profession as a whole. This places a significant responsibility on every member of the profession to contribute as fully as s/he is able. Therein lays the significance of nurturing learning communities as a focus for teaching and learning professionalism in medical education.

In summary, involved professionalism ties together knowledge, individual responsibility, collective responsibility and responsiveness to society. It is offered as a framework for health practitioners, policy makers and medical educators.

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