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COMMENTARY

Professionalism: Etiquette or Habitus?

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The past decade has witnessed an outburst of interest and scholarship about medical professionalism. The professionalism movement has a strong presence in medical education, including efforts to define, measure, and instill professionalism as a core competency of medical practice. As these efforts continue, there has been a shift toward emphasizing measurable behaviors while downplaying the internalization of values and virtues. As such, we have concerns regarding the ability of medical students and physicians to display outward professional behavior in a sustainable way without actually internalizing the values of the medical profession.

Kahn[1] argues for an "etiquette-based medicine," which stresses behavior mastery over character development. He proffers a list of behaviors that include actions such as shaking hands with a patient, smiling at a patient, and explaining one's role on the medical team. This emphasis on deportment is attractive for those who wish to approach trainee comportment as a checklist. Just as checklists are used in intensive care units to reduce central catheter infections, Kahn explicitly endorses etiquette checklists for physician trainees in an attempt to reduce negative patient encounters. This raises the question, though, of how Kahn's account distinguishes the physician-patient relationship from any other customer service profession. Kahn acknowledges that "the goals of the doctor differ in obviously important ways from those of a Nordstrom employee." However, we ask, "Does an approach to professionalism that focuses exclusively on behaviors provide any meaningful distinction between the patient-physician relationship and the relationship between a Nordstrom employee and a customer?" The behavioral checklist Kahn describes could apply to any customer service personnel. If the practice of medicine is about more than customer service, the prioritization of behavior over character development fails to address this difference.

Lesser et al[2] also adopt a behavioral view of professionalism, advancing several conclusions, including (1) professionalism is not an innate trait, (2) more behavioral examples of professionalism are needed, and (3) professionalism is a lifelong pursuit influenced by environment and context. The professionalism milestones for graduate medical education are another example of the behavioral checklist framework for professionalism.[3]

We agree with both Kahn and Lesser et al that medical professionalism is a competency that must be developed and formed in particular social contexts and must display itself publicly and behaviorally. Nonetheless, the call for specific examples of professional behaviors should not be viewed as a mandate to create an exclusively behavior-oriented definition. Examples and definitions are 2 different epistemologic creatures. Definitions tend not to reflect the complexities of a given issue, this being particularly true for professionalism because it exists within occupational and public sectors, is both socially dynamic and relationally grounded, and is widely acknowledged to be resistant to consensus.[4,5]

In addition, checklists of behaviors, however exhaustive, are not sufficient to guide physicians who seek virtue and excellence. Any checklist is both arbitrary (in what it includes vs leaves out) and by necessity incomplete (it must be strategically focused). Moreover, although behavioral ideals and warning signs drawn from past circumstances may inform future actions, they do not necessarily provide physicians with a sufficient foundation to approach the unanticipated challenges to professionalism that arise from novel situations.

The frameworks described by Kahn and Lesser et al construct a divide between behavior on one hand and attitudes and traits of character on the other. For example, Kahn states that etiquette-based medicine "would stress practice and mastery over character development."[1] Likewise, Lesser et al[2] write that "just as professionalism emanates from actions not virtues, the functionality of the health care system also emanates from the myriad intersecting

and interacting behaviors of multiple agents." Such a construction suggests the presence of an internal-external, mind-body split in which (external) professional behavior can be manifest apart from (internal) virtue and vice versa. We suggest that such a distinction is artificial and contrary to the ultimate purpose of medical professionalism, which seeks to wed the internalization of professional values with the outward display of behavior.

Instead, what is needed is a framing of professionalism in which virtuous behavior works itself so deeply into the marrow of the physician that it becomes "second nature," a teleologic *habitus*, exhibiting itself freely and easily even in challenging clinical situations and in which no virtuous character is admitted to exist unless it so displays itself. Such, we believe, is the proper understanding of virtue as proposed by Aristotle, particularly in his concept of *phronesis* or practical wisdom.[6] The virtuous physician, for Aristotle, is the one who has been so shaped and formed by teachers of excellence that excellent practice shows itself even in novel or unpredictable situations; a student so habituated would be disposed to navigate virtuously the complexities abundant in health care. A specific formula or behavioral repertoire, by contrast, may render professionalism piecemeal and therefore incomplete.

Our framework supports Kahn's acknowledgment that character formation is most effective when it resembles apprenticeship and not graduate school.[1] The apprenticeship model is necessary for trainees to develop not only the technical skills required by the specialty but also the virtues necessary for that practice.

Learning systems in which behavior deposes virtue as the pedagogic raison d'être may also spawn a sense of cynicism, resistance, and the behaviors of "faking it" and gamesmanship among trainees. Underlings, particularly in hierarchical and high-stakes environments, posture, slurp, or strive to look the part, regardless of what they actually believe or understand. Because checklists are prioritized over character, finesse rather than true professionalism becomes the rule of the day. The resulting milieu of socialization becomes essentially chameleon in nature. Being professional ceases to be part of the equation. Although it is correct that we become virtuous by behaving well, Aristotle was quite aware that one could behave well without being a good person and that such behaving well, underscored by intentional deception, would be neither pleasurable nor sustainable in the long run.[6] Action is the display of habit, neither internal nor external but both at the same time. Trainees and role models are authentic when they embody and display virtue in this way. A truly professional physician is one who can be trusted to do what is right when stressed, burned out, and especially when no one else is watching.

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