LCC Session One

Introductions

Professionalism

What will happen in this session?

Part 1.

Suggested Time 30 minutes.

This introductory session will allow you to meet your group and your facilitators.

- **Introductions**: The key task for this week is to create an enriching learning environment in which a productive and healthy group can form. Within effective learning environments, each group member takes responsibility for making the LCC experience meaningful and worthwhile. The first step in the creation of an enriching learning environment is to get to know each other.
- **Group Process:** Your LCC group stays together for the academic year, and much interpersonal learning takes place within the group. You will find that your LCC group is an important "learning lab" where you will benefit from the experiences of your facilitators as well as your colleagues. The best groups become safe spaces where students can explore their developing identities as physicians. Groups take time to evolve, and require constant attention in order to make them function optimally.

  Another task for today is to talk about the way you'd like your group to work. Think about what you need to do to create a safe space for the group, a space where each individual will feel a sense of ease. You may wish to create a set of group norms that will help to foster an environment of thoughtful inquiry and respect. Topics such as confidentiality, punctuality, preparing for sessions, and communicating absences may all be explored. You may also want to explore how the sessions will run, will students be taking turns in leading the sessions etc.

Part 2.

Suggested Time 30 minutes.

Professionalism: Attire and Behaviour

Residents will be expected to read the articles listed prior to the session and come prepared to discuss professionalism, Attire and Behaviour.

Readings:

1. **What to wear today? Effect of doctor's attire on the trust and confidence of patients.**
2. **When Young Doctors Strut Too Much of Their Stuff.**
3. **Tips for Working with Patients.**
4. **Becoming a Professional.**

The American Journal of Medicine (2005) 118, 1279-1286

ELSEVIER

THE AMERICAN JOURNAL *of* MEDICINE®

CLINICAL RESEARCH STUDY

What to wear today? Effect of doctor's attire on the trust and confidence of patients

Shakaib U. Rehman, MD,[a,b] Paul J. Nietert, PhD,[b,c] Dennis W. Cope, MD,[d,e] Anne Osborne Kilpatrick, DPA[f]

[a]Ralph H. Johnson Veterans Affairs Medical Center, Charleston, SC; [b]Department of Medicine and [c]Department of Biostatistics, Bioinformatics, and Epidemiology, Medical University of South Carolina, Charleston, SC; [d]University of California at Los Angeles (UCLA) San Fernando Valley Program and [e]Olive View-UCLA Medical Center, Sylmar, Calif; [f]Department of Health Administration and Policy, Medical University of South Carolina, Charleston, SC.

KEYWORDS:
Physician attire;
Physician dress;
Patient trust

ABSTRACT

PURPOSE: There are very few studies about the impact of physicians' attire on patients' confidence and trust. The objective of this study was to determine whether the way a doctor dresses is an important factor in the degree of trust and confidence among respondents.

METHODS: A cross-sectional descriptive study using survey methodology was conducted of patients and visitors in the waiting room of an internal medicine outpatient clinic. Respondents completed a written survey after reviewing pictures of physicians in four different dress styles. Respondents were asked questions related to their preference for physician dress as well as their trust and willingness to discuss sensitive issues.

RESULTS: Four hundred respondents with a mean age of 52.4 years were enrolled; 54% were men, 58% were white, 38% were African-American, and 43% had greater than a high school diploma. On all questions regarding physician dress style preferences, respondents significantly favored the professional attire with white coat (76.3%, $P < .0001$), followed by surgical scrubs (10.2%), business dress (8.8%), and casual dress (4.7%). Their trust and confidence was significantly associated with their preference for professional dress ($P < .0001$). Respondents also reported that they were significantly more willing to share their social, sexual, and psychological problems with the physician who is professionally dressed ($P < .0001$). The importance of physician's appearance was ranked similarly between male and female respondents ($P = .54$); however, female physicians' dress appeared to be significantly more important to respondents than male physicians' dress ($P < .001$).

CONCLUSION: Respondents overwhelmingly favor physicians in professional attire with a white coat. Wearing professional dress (ie, a white coat with more formal attire) while providing patient care by physicians may favorably influence trust and confidence-building in the medical encounter.

The patient-physician relationship is the foundation for all patient care. Research has demonstrated that a patient's initial consultation plays a vital role in the development of this relationship.[1] During this consultation, a patient will develop a first impression of his or her physician[2] based upon the physician's verbal and nonverbal communication, as well as personal attributes like clothing, grooming, and cleanliness. This article examines respondents' preferences to their physician's attire, one component of this first impression. Sociologists and psychologists have long recognized the effect of one's appearance on important life ex-

This work was supported in part by Department of Veterans Affairs Research Services.

Requests for reprints should be addressed to Shakaib U. Rehman, MD, Ralph H. Johnson Veterans Affairs Medical Center, Medical University of South Carolina, 214 Historic Drive, Mount Pleasant, SC 29464.

E-mail address: rehmans@musc.edu.

0002-9343/$ -see front matter © 2005 Elsevier Inc. All rights reserved.
doi:10.1016/j.amjmed.2005.04.026

periences such as interpersonal relationships and job-related successes.[3-6] In fact, the importance of physician dress on the patient-physician relationship can be traced back to Hippocrates, who stated that the physician "must be clean in person, well dressed, and anointed with sweet-smelling unguents. . ."[7]

Even in ancient societies, the way healers dressed played an important part in rituals of healing.[8] More recently, one can find a variety of personal opinions about the dress and appearance appropriate for physicians as reflected in editorials and letters.[9-27] Review of the existing literature about physicians' dress style revealed conflicting findings. Many studies found that patients favored a more traditional dress style for physicians, yet there are studies showing that patients preferred physicians in a more casual outfit. In a pioneer study in 1987, Dunn et al reported that 65% of 200 patients wanted their physicians to wear a white coat during a consultation, and the majority believed that physicians should wear formal dress.[28] Many studies reported similar outcomes and the traditional items of attire such as formal dress, a name tag, and a white coat were suggested by respondents as appropriate attire for physicians.[6,29-35] In one study, a majority preferred their doctor to wear a white coat, be free of political badges, and for men to have conventional length hair; however, most patients did not mind a male doctor with an earring, a woman in trousers, or a man without a tie.[35] A study performed among teenage patients actually measured patient attitudes after encounters with physicians whose dress varied from "very informal" to formal; the results were that dress style made no statistical difference in patient attitudes toward their physician.[36] In other studies, most of the patients claimed that the attire of the physician had no influence on their choice of family physician[37] or satisfaction.[38] The two studies that assessed the impact of dress in actual patient encounters found it to be an insignificant factor overall.[36,38] However, very few studies have examined the impact of physician attire and appearance on the confidence and trust in physicians by patients. No studies have assessed the effect of physician attire on patient adherence to prescribed regimens. In addition, no studies have assessed patient preferences for physician attire in an internal medicine outpatient setting. The purpose of this study was to determine whether the way a doctor dresses is significantly associated with patient self-report of their trust and confidence in physicians.

Methods

Subjects were administered a survey to assess the self-expressed degree of patient trust, confidence in physicians, and adherence to prescribed regimens. The study used a randomized cross-sectional design, which made use of survey methodology. Before the administration of the surveys to the study subjects, the survey's reliability and validity were tested. Two researchers familiar with instrument development and clinical research assessed the questionnaire's content validity. After a slight revision, the questionnaire was then administered to the clinical staff and nurses to assess clarity and ease of use. Ten volunteers took the survey and expressed that they did not have any trouble understanding the survey questions and would not hesitate to take the survey again if needed. The questionnaire was administered to the same group again after a month to test the reliability and consistency of answers. This pilot testing produced a reliability of 90%. The study was approved by the institutional review boards of the participating Veterans Administration (VA) and the University.

After determining that the instrument was valid and reliable, a convenience sample of patients and visitors in the waiting room of internal medicine outpatient clinics at the Ralph H. Johnson VA Medical Center participated during a 6-month period in 2003, from January through June. If a patient was accompanied by one or more persons, only one of them was selected to participate. We did not record whether the subject was a patient of that clinic or an accompanying visitor. However, because we wanted to ensure that approximately half of the subjects were female, and because most of the VA clinic patients are male, it is highly conceivable that the majority (but not all) of the female subjects were not clinic patients and that the majority (but not all) of the male subjects were clinic patients. Subjects who were demented, noncommunicative, or blind were excluded from the study. Demographic information was collected on each participant. Subjects completed the questionnaire after reviewing pictures of physicians attired in a variety of styles (Figure 1). Questions were asked about their preference for physician attire within the context of several scenarios as well as their trust and willingness to discuss sensitive issues with their physician.

The prespecified sample size chosen for the study was 400 respondents to ensure high (≥90%) statistical power to detect significant differences across groups. Respondents were randomized into 1 of the following 4 groups:

- Respondents who were shown the photographs of a "white male doctor" dressed in 4 different styles as described below (Figure 1a).
- Respondents who were shown the photographs of a "white female doctor" dressed in 4 different styles as described below (Figure 1b).
- Respondents who were shown the photographs of an "African-American male doctor" dressed in 4 different styles as described below (Figure 1c).
- Respondents who were shown the photographs of an "African-American female doctor" dressed in 4 different styles as described below (Figure 1d).

Each patient saw only one set of photographs, comprising 4 photographs of one of the above doctors (ie, the same doctor) in each of following styles of dress:

- Business attire (suit with neck tie for male physician, either tailored trouser or skirt for female physician)

Figure 1 (a) White male doctor dressed in 4 different styles. (b) White female doctor dressed in 4 different styles. (c) African-American male doctor dressed in 4 different styles. (d) African-American female doctor dressed in 4 different styles.

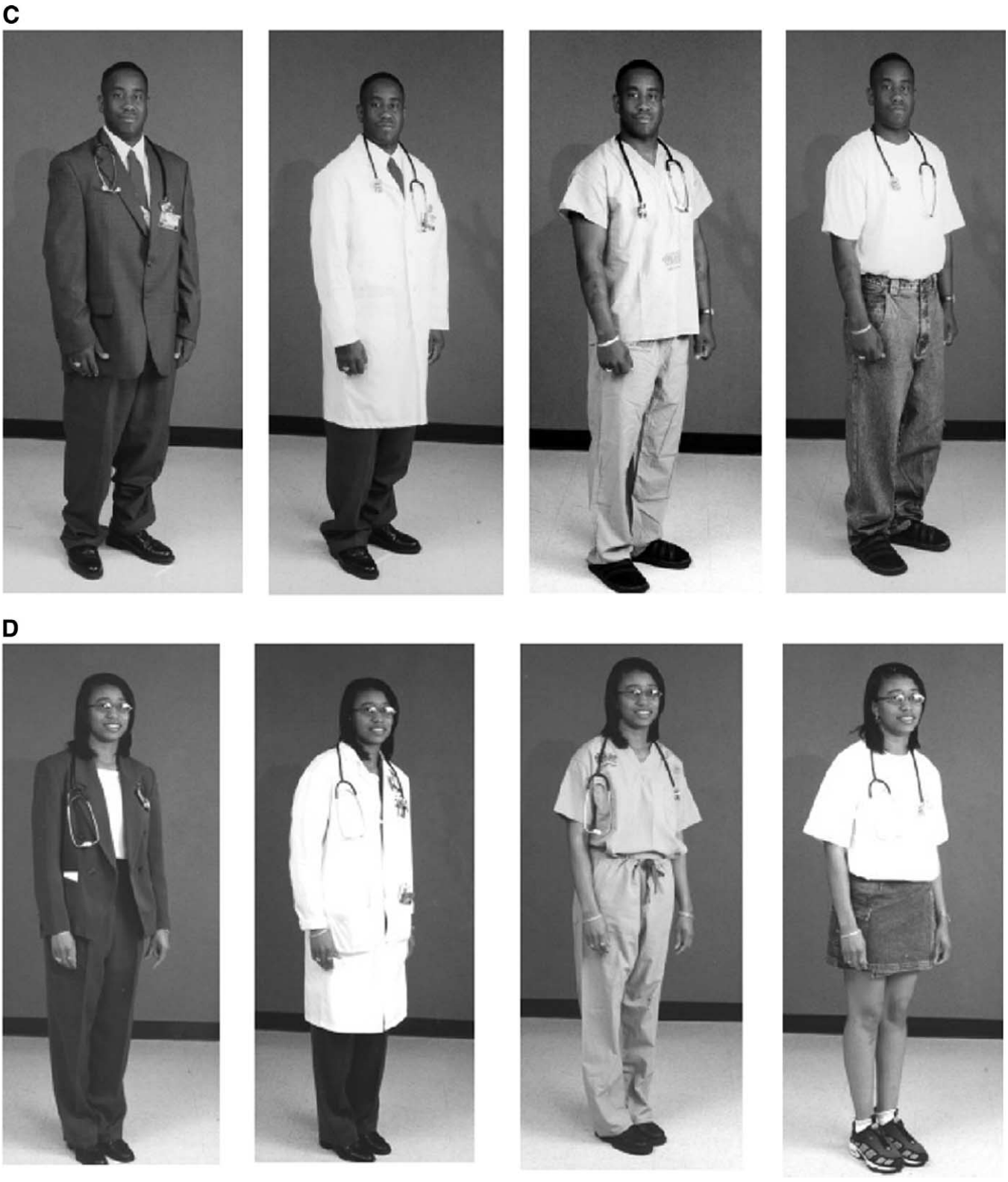

Figure 1. *Continued.*

- Professional attire (shirt, neck tie, and white coat for male, tailored trouser or skirt with white coat for female
- Surgical scrubs for both male and female
- Casual attire (jeans and T-shirt for male, jeans or short skirt for female)

In each physician's 4 photographs, the same background was used, and the following physician characteristics were identical: hairstyle, name tag, physical appearance (except for their attire), facial expression, presence of stethoscope, and jewelry. Thus the style of

Table 1 Characteristics of study participants (n = 400)

Characteristic	Value
Age (mean ± SD)	52.4 ± 18.9
Sex (% male)	53.8
% white	57.5
% African-American	38
Education (% >high school)	42.8
Born in South Carolina (%)	59.0

dress was the only variant across each of the physician's 4 photographs.

In the questionnaire, subjects were asked to report their preferences for each of the 4 styles of dress. In addition, subjects reported on their trust, confidence and willingness to share their social, sexual, and psychological problems with the physician in each of the pictures. Subjects also rated how strongly they felt about the importance of their physician's appearance. Using chi-squared tests, responses to the questionnaire items were compared across patient age groups, race, and sex, as well as the race, sex, and dress style of the physician. Because a substantial (47.8%) proportion of participants chose professional attire for *all* questions regarding preferred style of dress, a multivariate logistic regression model incorporating patient and physician characteristics was created to determine which characteristics were independently and significantly associated with the preference for professional attire. Results of the logistic regression model were summarized using odds ratios and their respective 95% confidence intervals. Lastly, chi-squared tests were used to determine which patient factors were significantly associated with their response to the question pertaining to the importance placed by respondents on their physician's appearance.

Results

Characteristics of study participants are listed in Table 1. Of the 400 respondents, 54% were white and 38% were African-American. Table 2 demonstrates that, in response to each of the preference questions about physician attire, there is a clear choice among respondents for professional attire. The chi-squared tests indicated that the preference patterns were all highly significantly different from an equal preference among the 4 various styles of dress. On average, across all preference questions, respondents overwhelmingly preferred professional attire (76.3%), followed by surgical scrubs (10.2%), business dress (8.8%), and casual dress (4.7%). Respondents' trust and confidence was significantly associated with preference for professional dress. Respondents also answered that they were significantly more willing to share their social, sexual, and psychological problems with the physician who is professionally dressed. The importance of physician's appearance was ranked similarly between male and female respondents ($P = .54$); however, the appearance and dress of female physicians appeared to be significantly more important than the appearance and dress of male physicians ($P < .001$). This finding was largely driven by the fact that female respondents placed more ($P < .001$) importance on female physicians' attire than male physician's attire; male respondents ranked the importance of attire relatively equally ($P = .13$) between male and female physicians.

Table 2 Results of physician attire questionnaire

	Attire of preferred physician				
Question	Business	Professional	Surgical	Casual	*P* value*
Which would you prefer					
For a routine physical examination?	4.8	81.8	11.8	1.8	<.0001
To be your family doctor?	15.3	75.8	6.8	2.3	<.0001
For an emergency (eg, heart attack)?	2.5	61.8	32.0	3.8	<.0001
To discuss intimate social and sexual problems?	12.5	71.3	7.8	8.5	<.0001
To discuss psychological problems?	16.5	68.0	6.5	9.0	<.0001
For a minor medical problem (eg, a cold)?	7.0	71.8	12.8	8.5	<.0001
Which of these doctors					
Would you trust the most?	7.0	80.5	8.3	4.3	<.0001
Would you be more likely to follow their advice?	6.5	82.3	7.8	3.5	<.0001
Would you have the most confidence in their diagnosis and treatment?	5.5	83.8	8.8	2.0	<.0001
Would you return for follow-up care?	4.8	81.0	8.8	5.5	<.0001
Which of these doctors would you expect to be					
More knowledgeable and competent?	9.8	80.7	7.8	1.8	<.0001
More caring and compassionate?	6.0	74.0	9.5	10.5	<.0001
More responsible?	9.0	79.5	8.3	3.3	<.0001
More authoritative and in control?	16.5	75.3	6.8	1.5	<.0001

**P* values were derived from chi-squared tests for specified proportions.

Table 3 Results of the logistic regression model predicting whether or not the study participant preferred professional attire for all of the 14 preference questions

Characteristic	Odds ratio	95% confidence interval	*P* value
Patient characteristics			
Age	1.03	(1.01, 1.04)	<.0001
Female sex	0.87	(0.55, 1.39)	.566
African-American race	1.10	(0.68, 1.80)	.693
Education past high school	1.78	(1.08, 2.95)	.025
Born outside South Carolina	1.92	(1.16, 3.17)	.011
Importance of physician's appearance	1.76	(1.41, 2.19)	<.0001
Characteristics of physician in photographs			
African-American race	0.64	(0.40, 1.02)	.059
Female sex	3.11	(1.95, 4.98)	<.0001

The results of the logistic regression model predicting whether or not the patient preferred professional attire in response to all 14 of the questionnaire items pertaining to attire preference are shown in Table 3. Older respondents were significantly more likely to prefer professional attire ($P < .001$). The odds of preferring professional attire was significantly greater among respondents with less than a high school education ($P = .025$), among respondents born outside of South Carolina, ($P = .011$), among respondents who feel more strongly about the importance of physician appearance ($P < .0001$), and among respondents who only viewed photographs of female physicians ($P < .0001$). No significant independent associations were noted between the professional attire preferences and patient sex or race of physician in the photographic array. However, African-American respondents placed significantly greater importance on physician appearance than did whites ($P < .0001$). Finally, respondents who viewed photographs of female physicians reported that they placed significantly greater importance on physician appearance than did respondents randomized to view photographs of male physicians ($P < .001$). A total of 82% of all subjects reported that physician appearance was important (ie, ≥3 on a scale from 1 [not at all important] to 5 [extremely important]) (Figure 2).

Discussion

In our study, respondents overwhelmingly favor professional attire with white coats for physicians. Our study results are similar to many other studies conducted worldwide in a variety of settings, except that none of the studies were conducted in the internal medicine outpatient setting.[28-35] Our study indicated that professional attire was associated with greater patient self-reported trust and confidence. This is similar to findings reported by McNaughton-Filion and colleagues, that the style of dress is an important consideration in a patient's ability to trust a physician.[31] However, no other study has explored the implication of physicians' appearance on respondents' readiness to discuss social, sexual, and psychological problems. In our study, respondents felt more comfortable talking about their sexual, psychological and more personal matters with physicians who dress more professionally. Additionally, respondents expressed a greater willingness to return for follow-up to professionally dressed physicians.

Previous studies have not assessed the impact of perception of doctors' dress on patient adherence and willingness to come back for follow-up. Our data suggest that physicians dressed professionally are positively associated with respondent commitment to adhere to prescribed therapy and an expressed desire to return for follow-up visits. There were some interesting findings pertaining to the subjects' race and physicians' sex in our study. African-American respondents placed significantly greater importance on physician appearance than did whites. To a greater degree than whites, African-Americans seem to feel more trusting of well-dressed physicians than physicians who are not as well dressed. In addition, subjects who were randomized to view photographs of female physicians placed greater importance on physicians' appearance than did those who were randomized to view photographs of male physicians. One possible explanation for this finding could be that because men have traditionally been more likely than women to become physicians, respondents may feel that women physicians

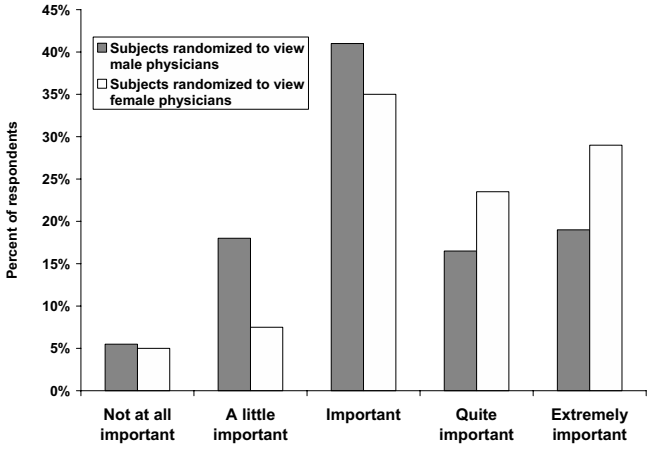

Figure 2 Respondents' ratings of importance of physician attire by sex of physician in photograph.

need to make an extra effort to appear professional, so that they are not confused with nurses, dietitians, social workers, etc (ie, professional groups that have traditionally been predominantly female). Other studies have reported similar results regarding this tendency among subjects to hold a different standard of dress for females than males.[31,33]

It is interesting to note that for medical emergencies, most people chose professionally dressed physicians as in all other scenarios, but the second best doctor in their opinion was the one in scrubs. We don't know if this response is due to their personal past experience or due to the effects of television media portraying scrubs-clad physicians in an emergency hospital setting. Another interesting finding is that when identifying their preference for caring and compassionate physicians, respondents chose doctors in casual attire for the second rank (10.5%), after professionally dressed physicians (74%). It was believed that in certain specialties, eg, psychiatry, not wearing a white coat reflects a more compassionate rather than authoritative image of physicians to patients;[39] however, Gledhill et al studied inpatient psychiatric patients and reported a positive effect of white coats.[39]

In this study, older respondents were significantly more likely to prefer professional attire ($P < .001$), which is similar to studies conducted elsewhere.[6,28,29] We did not collect physicians' own opinions about doctor dress. In other studies when physicians were asked to note their own preferences, it was reported that doctors mostly favored the traditional dress style compared with casual items, and this difference was more marked in the older age group of physicians.[6,28]

The limitations of our study are that it is a single-center study conducted at one VA medical center, and veterans and visitors may have chosen the professional attire due to their previous comfort level with the military uniform. Also, age of physicians may have been a confounding factor. That is, photographs in our study were showing younger-looking physicians; it is unclear whether respondents will give the same importance to the white coat if the photographs showed older physicians. The study was conducted in South Carolina, and it is possible that people in the south like more traditional attire for their physicians, and that those who live in other regions of the United States might have different preferences. We did not have enough respondents from other areas of the country and were thus not able to make meaningful regional comparisons.

This study found that when presented with a photograph of an unknown physician, before the development of a relationship or the initiation of an interpersonal interaction, respondents prefer professional attire. The survey of subjects in a waiting room looking at pictures assesses patient preferences and does not account for many other factors involved in communication in a doctor-patient encounter, such as physician demeanor, charisma, empathy, tone and volume of voice, etc. Therefore, it is uncertain that the study's findings of respondents' opinions can be extrapolated to face-to-face encounters evolving in real time. Additionally, self-report data do not provide an overall gauge of adherence or behavioral change, but an intention to comply. Future longitudinal studies might address whether first impressions might lead to a change in a long-term physician-patient relationship and whether behavior follows intentions. Observing behaviors over a longer period of time would be one way to address that issue, and part of the behavior observed could include assessing whether respondents were more likely to follow their physician's advice based on their attire. The question of regional differences could be addressed by conducting surveys in different parts of the nation and among different types of patients.

Nevertheless, in this study, respondents have indicated a strong preference for physicians in professional attire with a white coat, and have shown a strong intention to trust, to comply with their recommendations, and to return for follow-up to these physicians ($P < .0001$). Respondents also expressed the most confidence in physicians wearing professional attire with a white coat ($P < .0001$).

Conclusion

Patients and visitors to an internal medicine clinic in this study were overwhelmingly in favor of doctors wearing professional dress, ie, more formal attire with a white coat. We recommend that general internists consider wearing more formal attire with a white coat during patient care encounters, because it may favorably influence trust and confidence-building in the medical encounter. This is particularly important if this attire results in better adherence and thus positive health outcomes. Further study to assess the generalizability of these findings is suggested. These studies could include conducting a multicenter study and measuring adherence behaviors and stated attitudes toward physicians wearing different attire.

Acknowledgment

We thank Scott Stewart, MD; Sarah Melissa Mahoney, MD; Jerome Simmons, and Erica Hanesworth, Pharm D for modeling for photographs. We thank Mary Nashed, MB, and M. Hadi Ali Baig, MBBS, for assistance with logistics of the study. We are also thankful to John C. Baroody of Medical Media of Ralph H. Johnson V.A. Medical Center for his help in photographing our models.

References

1. Van Dulmen AM, Verhaak PFM, Bilo HJG. Shifts in doctor-patient communication during a series of outpatient consultations in non-insulin-dependent diabetes mellitus. *Patient Educ Couns*. 1997;30: 227-237.
2. Short D. First impression. *Br J Hosp Med*. 1993;50:270-271.

3. Goffman E. *The Presentation of Self in Everyday Life*. New York, New York: Doubleday and Co, Inc.: 22-24; 1959.
4. Rose A. *Human Behavior and Social Process*. Boston, Massachusetts: Houghton Mifflin Co.: 1962, 88-117.
5. Bersheild E, Gangested S. The social psychological implications of facial physical attractiveness. *Clin Plast Surg*. 1982;9:289-296.
6. Gjerdingen DK, Simpson DE. Physicians' attitude about their professional appearance. *Fam Pract Res J*. 1989;9:57-64.
7. *Hippocrates*, Volume II. Cambridge, Massachusetts: Harvard University Press:1923, 311-312.
8. Kleinman AM. The symbolic context of Chinese medicine: a comparative approach to the study of traditional medical and psychiatric forms of care in Chinese culture. *Am J Chin Med*. 1975;3:103-124.
9. Mayberry WE. The elements of style in medicine. *Mayo Clin Proc*. 1986;61:666-668.
10. Kriss JP. On white coats and other matters. *N Engl J Med*. 1975;292: 1024-1025.
11. Blumhagen DW. The doctor's white coat: the image of the physician in modern America. *Ann Intern Med*. 1979;91:111-116.
12. Lynch PI. The physician's clothes. *N Engl J Med*. 1975;293:1270.
13. Hughes E, Proulx J. You are what you wear. *Hospitals*. 1979;53:113-114, 116-118.
14. Rabson SM. Coats: white or soiled. *N Engl J Med*. 1975;293:563-565.
15. Davis BF. Letter. *N Engl J Med*. 1975;293:563.
16. Engleman EG. Letter. *N Engl J Med*. 1975;293:563-564.
17. Barr RW. Letter. *N Engl J Med*. 1975;293:564.
18. Mulligan WJ. Letter. *N Engl J Med*. 1975;293:564.
19. Newgard K, Rollow B, Walleigh L, et al. Letter. *N Engl J Med*. 1975;293:564-565.
20. Hedberg SE. Clothes and confidence. *N Engl J Med*. 1969;280:620.
21. Blondell RD, Humble RS, Roberts DM. Patients and the habits of house officers. *JAMA*. 1987;257:2031.
22. Koumbourlis AC. Letter. *JAMA*. 1987;257:2032.
23. Dunn JJ, Lee TH, Percelay JM et al. Patient and officer attitudes on physician attire and etiquette (letter). *JAMA*. 1987;257:2032.
24. Gilder SS. Clothes make the doctors. *S Afr Med J*. 1987;72:523.
25. Mitchell SR. The art of wearing the white coat: advice to the new medical graduate. *Pharos*. 1986;49:31-35.
26. Handler S. On medical manners and mores. *Minn Med*. 1981;64:149.
27. Francis V, Korsch B, Morris M. Gaps in doctor-patient communication. *N Engl J Med*. 1969;280:535-540.
28. Dunn JJ, Lee TH, Percelay JM, et al. Patient and house officer attitudes on physician attire and etiquette. *JAMA*. 1987;257:65-68.
29. McKinstry B, Wang J. Putting on the style: what patients think of the way their doctor dresses. *Br J Gen Pract*. 1991;41:275-278.
30. Cha A, Hecht BR, Nelson K, Hopkins MP. Resident physician attire: does it make a difference to our patients? *Am J Obstet Gynecol*. 2004;190:1484-1488.
31. McNaughton-Filion L, Chen JS, Norton PG. The physician's appearance. *Fam Med*. 1991;23:208-211.
32. Gjerdingen DK, Thorpe W, List-Holt P. The physician's appearance and professionalism. *Resid Staff Physician*. 1990;36:65-74.
33. Gjerdingen DK, Simpson DE, Titus SL. Patients' and physicians' attitudes regarding the physician's professional appearance. *Arch Intern Med*. 1987;147:1209-1212.
34. Keenum AJ, Wallace LS, Stevens LR. Patients' attitudes regarding physical characteristics of family practice physicians. *South Med J*. 2003;96:1190-1194.
35. Dover S. Glasgow patients' attitude to doctors' dress and appearance. *Health Bull (Edinb)*. 1991;49:293-296.
36. Neinstein LS, Stewart S, Gordon N. Effect of physician dress styles on patient-physician relationship. *J Adolesc Health Care*. 1985;6:456-459.
37. Manahem S, Shvartzman P. Is our appearance important to our patients? *Fam Pract*. 1998;15:391-397.
38. Ikusaka M, Kamegai M, Sunaga T, et al. Patients' attitude toward consultations by a physician without a white coat in Japan. *Intern Med*. 1999;38:533-536.
39. Gledhill JA, Warner JP, King M. Psychiatrists and their patients: views on forms of dress and address. *Br J Psychiatry*. 1997;171: 228-232.

November 21, 2006

ESSAY

When Young Doctors Strut Too Much of Their Stuff

By ERIN N. MARCUS, M.D.

MIAMI, Nov. 20 — When I was a new faculty physician, I worked with a resident doctor who was smart and energetic and took excellent care of her patients.

There was just one problem. As she delivered her thoughtful patient presentations to me and the other attending doctors, it was hard not to notice her low-cut dress.

“You two have to say something to her,” one of my male colleagues said to me and another female doctor one afternoon. But while none of us would have hesitated to intervene had she prescribed the wrong drug for a patient, we felt weird saying something to her about her clothes. So we didn’t.

Nearly a decade later, my impression is that more young physicians and students are dressing like that resident. Every day, it seems, I see a bit of midriff here, a plunging neckline there. Open-toed sandals, displaying brightly manicured toes, seem ubiquitous.

My observations may partly reflect the city in which I work, Miami, a subtropical place known for its racy clothes. But colleagues who practice elsewhere report that they, too, have seen medical students and young doctors show up for clinical work in less-than-professional attire.

“Poor choice is not regional — I’ve seen it everywhere,” said Dr. Pamela A. Rowland, a behavioral scientist and director of the office of professional development at Dartmouth Medical School, who has studied the impact of physician clothing on patient confidence. “It always surprises me when there are dress codes for staff but not for physicians.”

Among older and middle-aged physicians (like myself), tales of salacious and sloppy trainee attire abound. One colleague commented that a particularly statuesque student “must have thought all her male patients were having strokes” when she walked in their exam room wearing a low-cut top and a miniskirt. Another complained about a male student who came to class unshaven, even though he hadn’t been on call the night before. One Midwestern medical school dean reported that her school instituted a formal dress policy after administrators noticed students revealing too much flesh while sunbathing on a small patch of grass outside the school building, directly below

patients' hospital room windows.

Patients and colleagues may dismiss a young doctor's skills and knowledge or feel their concerns aren't being taken seriously when the doctor is dressed in a manner more suitable for the gym or a night on the town. There are also hygiene considerations: open-toed shoes don't protect against the spills that commonly occur in patient care, and long, flowing hair can potentially carry harmful bacteria.

"Patients don't have your c.v. in front of them, and appearance is all they have to go by," Dr. Rowland said. "If you don't meet their expectations, their anxiety level increases."

In a study published last year in The American Journal of Medicine, patients surveyed in one outpatient clinic overwhelmingly preferred doctors photographed in formal attire with a white coat to photos of doctors in scrubs, business suits and informal clothes — jeans and a T-shirt for men, an above-the-knee skirt for women. The patients also said they were more likely to divulge their social, sexual and psychological worries to the clinicians in the white coats than to the other doctors.

Plaintiffs' attorneys sometimes ask about a doctor's attire in malpractice depositions, Dr. Rowland said. Her research has also found that physician clothing can influence scores on board certification oral exams, in which a senior doctor assesses a younger doctor's medical knowledge.

"You don't want to look too attractive to be serious," she said, adding that "a certain amount of the nerd factor" can help a doctor's performance.

Historically, doctors have dressed differently from the rest of the population, and the doctor's uniform in the Western world continues to evolve. Hippocrates advised doctors to be "clean in person" and "well dressed" but also recommended that they be "plump" and anoint themselves with "sweet-smelling unguents." The white coat itself became a staple for Western doctors in the early 20th century. More recently, the British Medical Association recommended that doctors on hospital wards not wear ties, because they are seldom washed and can carry antibiotic-resistant bacteria.

Many medical schools have dress codes (my employer, the University of Miami, specifies that students have hair "of a natural human color," among other things). But enforcement is often left up to faculty members and thus can be haphazard.

Last year, I sent home an otherwise excellent student because her feet were clad in shoes that looked like flip-flops (though she claimed they were expensive leather sandals). I felt guilty about it at the time, since it meant she missed an afternoon of clinic. But I doubt she'll ever wear them in front of patients again.

And I wonder about that resident with whom I worked many years ago. Do patients and colleagues underestimate her abilities? Ultimately, we didn't do her a favor by pretending to ignore her clothes.

Dr. Erin N. Marcus is a general internist and assistant professor of clinical medicine at the University of Miami Miller School of Medicine.

Tips for Working with Patients

Dress: Credibility as a physician is partially based on first impressions. Patients have a strong preference for professional dress.

Grooming: Sorry for being obvious - but these things must be said.
Dress codes are the bane of all teaching programs - ask any program director, and they will tell you how difficult it is. No one is happy telling someone that their dress, appearance or body odour could have a potential impact on patient care. Get it right from the start so it isn't an issue during your residency. There is lots of time for individual expression and fashion flare when you aren't caring for patients. Medicine isn't about you – it's about them.
Just for fun, do a quick discussion of what members of your group are wearing right now. Would you, personally, feel comfortable caring for patients as you are? What would you or your colleague need to consider to achieve a "professional" look?

For men, collared shirt and dress pants at minimum.

For women, conservative clothing - no midriffs, no plunging or revealing necklines, nothing skin-tight.

Your name tag should be easily visible and in an appropriate spot. Avoid hanging your name tag from your belt making the patient stare at your crotch to read your name.

No furry teeth

Make sure your hands are very clean, fingernails trim and even.

Consider body odour. Not everyone uses deodorant but if you don't, you run the risk of being unaware of how you might smell to other people. Ask someone you trust for feedback.

Do not wear scented products such as perfume/cologne/aftershave – these days, many people have sensitivities to scented products

Showing Up: Again, it's so obvious (but you would be amazed)
I guarantee your preceptors will be even happier to give you a glowing recommendation if you show up on time and follow through with any commitments you make or communicate in advance, if you can't.
Office Staff are people, too**.** Want to make a VERY good impression?
Staff in the Postgrad office swear that they can tell a student who will have difficulty – or one who will be outstanding - even before residency starts, based on the quality of interactions students have with them during the admissions and orientation process.
Getting clear about expectations: Preceptors and students have different degrees of comfort and familiarity with discussing expectations. However, this is your learning - you will get much more out of it if you are proactive.
It's much easier to do this at the beginning than try to regain lost ground. Again, having the skills to do this in a friendly, proactive way will set you head and shoulders above the average, passive resident.
Be respectful of patients and colleagues.

Be there 10 minutes early

Show up prepared. Have a pen, your stethoscope and whatever else you think you need.

If something happens and you can't get there at the appointed time, call and let them know. This means that before your very first appearance, you have confirmed contact details and know the backline number or pager number you will need in case you need to communicate an unexpected event.

Treat everyone in the office/on the ward with courtesy and respect.

If you are going to a rotation for a few weeks, introduce yourself to the administrative staff. Ask if there is anything you can do to make your rotation easier for him/her. Ask what the best way to communicate with the office is.

Before any rotation, ask if you can spend a few minutes going over expectations.

Ask your preceptor how they prefer to give you feedback - a brief summary at the end of every day or once a week can be helpful.

Let your preceptor know you would like "timely feedback". Feedback given as close to the event as possible is more effective then feedback given long after the event has happened.

Clarify a date or general time for your mid-unit and end-unit evaluation.

You might even ask if there is anything your preceptor would like feedback on during your time together.

Do not call parents, by their first names unless they ask you to. Give them the dignity of using their last name and title -- "Mr.", "Ms." or "Mrs."

Try not to label patients. Don't make jokes about patients or say things that might undermine a patient's trust in you or your colleagues.

REVIEW ARTICLE

MEDICAL EDUCATION

Malcolm Cox, M.D., and David M. Irby, Ph.D., Editors

The Developing Physician — Becoming a Professional

David T. Stern, M.D., Ph.D., and Maxine Papadakis, M.D.

From the Departments of Internal Medicine and Medical Education, University of Michigan Medical School and the Veterans Affairs Ann Arbor Healthcare System — both in Ann Arbor (D.T.S.); and the Office of the Dean, Student Affairs, Department of Internal Medicine, University of California, San Francisco, and the Veterans Affairs Medical Center — both in San Francisco (M.P.). Address reprint requests to Dr. Stern at the University of Michigan Medical School, 300 N. Ingalls, Rm. 7E02, Ann Arbor, MI 48109, or at dstern@umich.edu.

N Engl J Med 2006;355:1794-9.

We all reflect on our formal training in medicine and know that somehow we made the transition from being a student in a classroom to being a seasoned clinician caring for patients. We spent years acquiring the knowledge and skills necessary to function as a physician, and part of that learning was accomplished by following examples and by trial and error. Most of us are still learning how to be better "professionals," but we are building on a foundation that was developed in medical school and early postgraduate training. These educational and training environments have changed substantially in recent years, so it is pertinent to ask whether we are cultivating in current students and residents the professional behaviors we would seek should we need medical care.

When teaching students our core values, we must consider the real world in which they will work and relax.[1-4] The concept of "teaching" must include not only lectures in the classroom, small group discussions, exercises in the laboratory, and care for patients in clinic but also conversations held in the hallway, jokes told in the cafeteria, and stories exchanged about a "great case" on our way to the parking lot. This broad concept of teaching includes three basic actions: setting expectations, providing experiences, and evaluating outcomes (Table 1).[5,6] Although the literature on professionalism generally focuses on only one or another of these three tasks,[7] a comprehensive program requires us to address all three.

Setting Expectations

Remembering back to your own first day on the wards as a third-year medical student, you can probably still feel the anxiety and uncertainty. Each rotation brought a new set of rules, a new set of behavioral norms, and a new community of physicians and health care professionals with whom to engage. When is it appropriate for a medical student to disclose test results to patients? What should you do if you discover an error that did not change a clinical outcome? Can a resident leave the bedside of a critically ill patient because patients are waiting to be seen in the resident's continuity clinic?

Unfortunately, the rules were unwritten and often discovered only when you made a mistake. It makes more sense to set explicit goals and expectations for students; for the most motivated, this may be the only step necessary. Through initiatives like those supported by the Arnold P. Gold Foundation, medical schools have moved professional expectations to center stage. Students at most schools now begin their first year with a "white-coat" ceremony, in which they learn the meaning of the responsibility that comes with wearing a white coat, the expectations for humanism and professionalism. This is also often the occasion when they recite the Hippocratic Oath or a similar oath of professionalism.[8] Orientation sessions

for preclerkship and clerkship experiences often communicate explicit expectations for professional behavior. The Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education have explicit expectations for professionalism,[9,10] including clear policies and procedures that define professionalism and delineate appropriate responses to unprofessional behavior. Continuing a public professing of principles[11] into the years of residency and practice is unusual but important to ensure that physicians remain committed to a common set of expectations for the profession. The Code of Medical Ethics from the American Medical Association and the Charter on Medical Professionalism[12] serve to advance these principles and expectations.

Table 1. Teaching Professionalism.

Setting expectations
White-coat ceremonies
Orientation sessions
Policies and procedures
Codes and charters
Providing experiences
Formal curriculum
Problem-based learning
Ethics courses
Patient–doctor courses
Community-based education
International electives
Hidden curriculum
Role models
Parables
The environment as teacher
Evaluating outcomes
Assessment before entry into medical school (multiple medical interview)
Assessment by faculty
Assessment by peers
Assessment by patients (patient satisfaction)
Multiperspective (360-degree) evaluation

PROVIDING EXPERIENCES

Until the late 1970s, the formal teaching of ethics, professionalism, and humanism was not part of the medical school curriculum.[13] Since then, educators have developed innovative curricular experiences to expose students to issues of professionalism and promote knowledge of ethical principles,[14] skills of moral reasoning,[15] and the development of humanistic attitudes. One of the primary goals of problem-based learning (a group-learning process characterized by the shared creation of goals and the pursuit of knowledge) is the development of teamwork and leadership skills,[16] attributes central to professionalism. Most medical schools now require students to take a formal ethics course.[14] Courses on managing the doctor–patient relationship[17] generally include sessions in which students reflect on their experiences with patients and their developing professional persona. Obtaining experience in underserved communities and international settings often helps students understand the social role of physicians.[18,19] Although the face validity of such approaches is high, the effectiveness of these additions to the curriculum has not been formally tested.

Potentially more important than these formal elements of the curriculum are the informal experiences of medical students and residents.[1,2] A study of primary-school education was the first to label this sort of experience as part of the "hidden curriculum" — "the curriculum of rules, regulations and routines, of things teachers and students must learn if they are to make their way with minimum pain in the social institution called the school."[20] In the context of medical student education, the hidden curriculum of rules, regulations, and routines is transmitted mostly by residents (rather than faculty) in clinic hallways and the hospital, often late at night, when residents and students are on call.[21,22]

Teaching in the hidden curriculum happens through role modeling and the telling of parables as well as through the framework of the educational environment itself. Faculty often perceive themselves as role models for students and claim that this is one of the primary means through which they teach professionalism. But a role model is "someone who, in the performance of a role, is taken as a model by others."[23] Role modeling is in the eye of the beholder — the student, not the teacher. "Individuals who are seen as mentors may not realize that they are teaching professional values, and those not seen as mentors may believe that they are."[24]

Educators now believe that the act of role mod-

eling is insufficient.[24-26] Role modeling must be combined with reflection on the action[27,28] to truly teach professionalism. Attending physicians are not presumptuous enough to believe that if they simply prescribe the correct medication to a patient and leave the room without discussion that the students who are observing will learn to treat the disease. Similarly, modeling professional behavior on the part of a teacher (e.g., showing compassion to a dying patient or offering reassurance about recovery) without following up with discussion constitutes a missed opportunity for teaching professionalism.

Parables are a powerful means of transmission of cultural values; the norms of professional behavior have been handed down through generations of doctors using stories with meaning.[29-31] In medicine, parables often start with "I had this great case" or "When I was an intern."[32] What ensues is a story about a fascinating medical case with a moral about what it means to be a doctor. The published writings of William Carlos Williams, Jerome Groopman, Atul Gawande, and others take this process to its highest form. But these stories are exchanged every day in conversations over lunch, in the hallways, and outside the hospital — a story about how a patient survived when perhaps he should not have, a story about how you would have missed the diagnosis had you not stopped to ask one more question, a story about an observation from a nurse that alerted you to an unexpected problem. These stories not only serve to transmit professional values but also reveal the struggle of how we try (and sometimes fail) to meet the highest standards of professional conduct.[33] The tradition of storytelling is instructive for students, but building it into a formal curriculum is a challenge.

The health care environment itself can also have a pervasive effect on professional values. Perhaps some readers remember when patients' charts hung from the foot of the bed. In a world governed by the Health Insurance Portability and Accountability Act of 1996 and the computerized medical record, patient information is revealed only behind closed doors in a double-password–protected patient information system in which an advance warning tells you that all access is being tracked. Although there is ample reason for concern about confidentiality in a world where almost anyone's personal health information is only a few mouse-clicks away,[34] the environment itself actually does much of the teaching. An environment with high patient volumes and low staff-to-patient ratios has been shown to foster an attitude among residents that their job is to "get rid of patients."[35] Recent changes in residents' duty hours may have both positive and negative consequences for professional behavior.[36] For example, limiting duty hours may give residents time to take better care of themselves but may also limit the development of a trusting relationship with patients.

EVALUATING OUTCOMES

Even the clearest of expectations and the best of experiences will not guarantee professional development. Teachers must evaluate students both to determine whether the lessons were learned and to motivate students to learn what is important. Our present emphasis on the assessment of knowledge and skills has produced a technically competent pool of professionals. However, the absence of equally stringent methods for measuring professionalism leaves students and residents to consult their own moral compasses about what constitutes professional behavior.[37]

In the past decade, methods for evaluating professionalism have been developed and applied in many different medical settings.[38,39] The best capture the behaviors of students in real-world contexts in which they are called on to resolve a professional dilemma that is relevant to their everyday lives.[40] First-year medical students may struggle with whether to cheat on examinations,[41] clinical clerks with how much of a resident's note to copy,[42] and practicing physicians with how much deception will be necessary to get a mammogram covered by an insurance provider.[43]

Measures of professionalism are no longer subjective. Innovative new admissions procedures are showing promise in detecting aspects of professional behavior even before a candidate enters medical school. For example, it is now possible to reliably predict interpersonal and communication skills with the use of multiple, brief standardized interpersonal interactions (the so-called multiple medical interview).[44] Preclinical students' thoroughness with routine administrative responsibilities correlates with faculty members' perceptions of professionalism in clerkships, with items as mundane as completing course evaluations and requests for immunization records being indi-

cators of professional behavior.[45] State medical board sanctions for unprofessional behavior are associated with negative comments by faculty on clerkship evaluation forms.[46,47]

Peer assessment, though perhaps useful only for formative purposes, is a promising avenue for assessing and promoting professionalism.[48] Patients' perceptions of physician conduct can help identify the minority of physicians who have consistent problems with professionalism[49] and help to reward those whose performance is exemplary. Use of a combination of these methods in a multidimensional, multiperspective (so-called 360-degree) professionalism assessment is now expected as part of medical school performance evaluation[50] and residency certification.[9]

TEACHING PROFESSIONALISM

Medical educators must set expectations, create appropriate learning experiences, and evaluate outcomes. Educators must be clear about professional expectations — both the rationale behind them and the consequences of failing to meet them. Without well-defined expectations, students will not have a clear ideal to strive for. Educators must design clinical experiences that allow students to see how seasoned practitioners negotiate the dilemmas of medical practice. Although we allow students to spend a full hour with a patient to take a history and perform a physical examination, busy physicians do not have that luxury. Inherent conflicts between what we teach and what students see in real-life settings will not promote professionalism.[22,51] At a minimum, such conflicts must be explained to students. Efforts to teach the ideals of professionalism can be easily overwhelmed by the powerful messages in the hidden curriculum.[7,52]

The goal of evaluation should be to reward the best professional behavior, enhance professionalism in all students, identify the few students who show deficiencies in professionalism, and dismiss the rare student who cannot practice professional medicine. However, even the best evaluation strategies will be undermined unless faculty are trained to promote the kind of role modeling that is so essential to a student's professional development. This kind of faculty development is not easy. How do we teach it in real time in the reality of today's academic environment? Professional development is complex[1,2]; it is a daunting challenge for individual teachers to both recognize the problem[53] and respond effectively.[54] How do we reach the faculty most in need of instruction in role modeling, who may also be the most resistant to it? Where will the resources for these interventions come from?

The solutions rest not only with developing our skills as teachers[25-28] but also with improving the environment in which we teach.[55] Students need to see that professionalism is articulated throughout the system in which they work and learn. In our academic medical centers, this means providing an environment that is consistently and clearly professional not only in medical school but throughout the entire system of care. The challenge becomes even more daunting when the goal is to institute an attitude of professionalism in multiple organizations.[56] Some of the most powerful and important interventions can be made at the administrative level[57]: removing barriers to compassionate care, ensuring access to care, designing efficient health care delivery systems, and acknowledging teamwork as a fundamental principle of health care. Improving the health care system will go a long way toward promoting the professionalism of students and trainees.

As we expect greater professionalism from our students, we need to expect the same from teachers and organizational leaders. Anything else is disingenuous. For example, students have every right to expect that mistreatment by residents and faculty is taken just as seriously as unprofessional behavior on the part of students.[58] Expanding the criteria for incentive pay from patient satisfaction alone[49] to include learners' satisfaction with professional interactions could serve to link assessment and reward.

Professional organizations must advocate for our identity as a profession that celebrates the primacy of patients' interests over self-interest[12,59] while acknowledging that physicians do have legitimate self-interests. Our profession is not a business, and we must resist redefining our patients as "managed care lives" or "consumers." At the same time, licensing boards need to take swifter action against unprofessional behavior because public safety and the public's trust of our profession are at stake.

Physicians are asked to deliver professional care in a complex and ever-evolving health care system, and medical educators have a critical role to play in maintaining and enhancing profes-

sionalism. This is, after all, our contract with society. Jordan J. Cohen, president emeritus of the Association of American Medical Colleges, writes, "Failing to deliver on these expectations . . . falling short on the responsibilities of professionalism, will surely result in a withdrawal of the tremendous advantages that now accompany our profession's status."[60] What is at stake is nothing less than the privilege of autonomy in our interactions with patients, self-regulation, public esteem, and a rewarding and well-compensated career. In pursuit of the highest ideals of professionalism in service to our patients, as well as in our own self-interest, medical educators would be wise to take a comprehensive view of the task at hand, setting clear expectations for behavior, designing meaningful experiences that promote professional values, and insisting on the widest possible application of robust behavioral outcome measures across the entire continuum of medical education and practice.

No potential conflict of interest relevant to this article was reported.

REFERENCES

1. Becker H, Geer B, Hughes EC, Strauss AL. Boys in white: student culture in medical school. Chicago: University of Chicago Press, 1961.
2. Merton RK, Reeder LG, Kendall PL. The student-physician: introductory studies in the sociology of medical education. Cambridge, MA: Harvard University Press, 1957.
3. Hundert EM, Douglas-Steele D, Bickel J. Context in medical education: the informal ethics curriculum. Med Educ 1996;30:353-64.
4. Hafferty FW, Franks R. The hidden curriculum, ethics teaching, and the structure of medical education. Acad Med 1994;69:861-71.
5. Dewey J. Experience and education. New York: Collier Books, 1963.
6. Eisner EW. The educational imagination: on the design and evaluation of school programs. Upper Saddle River, NJ: Prentice-Hall, 2002.
7. Inui T. A flag in wind. Washington, DC: Association of American Medical Colleges, 2003.
8. Wear D. On white coats and professional development: the formal and the hidden curricula. Ann Intern Med 1998;129:734-7.
9. Outcome Project. Chicago: Accreditation Council for Graduate Medical Education, 2005. (Accessed September 29, 2006, at http://www.acgme.org/outcome/comp/compHome.asp.)
10. Accreditation standards. Chicago: Liaison Committee of Medical Education, 2005. (Accessed September 29, 2006, at http://www.lcme.org/standard.htm.)
11. Wynia MK, Latham SR, Kao AC, Berg JW, Emanuel LL. Medical professionalism in society. N Engl J Med 1999;341:1612-6.
12. Medical Professionalism Project. Medical professionalism in the new millennium: a physician charter. Ann Intern Med 2002;136:243-6.
13. Evaluation of humanistic qualities in the internist. Ann Intern Med 1983;99:720-4.
14. DuBois JM, Burkemper J. Ethics education in U.S. medical schools: a study of syllabi. Acad Med 2002;77:432-7.
15. Self DJ, Baldwin DC Jr. Does medical education inhibit the development of moral reasoning in medical students? A cross-sectional study. Acad Med 1998;73:Suppl 10:S91-S93.
16. Davis MH, Harden RM. Problem-based learning: a practical guide. No. 15. Dundee, Scotland: Association of Medical Education in Europe, 1999.
17. Makoul G. Essential elements of communication in medical encounters: the Kalamazoo consensus statement. Acad Med 2001;76:390-3.
18. Thompson MJ, Huntington MK, Hunt DD, Pinsky LE, Brodie JJ. Educational effects of international health electives on U.S. and Canadian medical students and residents: a literature review. Acad Med 2003;78:342-7.
19. Mutchnick IS, Moyer CA, Stern DT. Expanding the boundaries of medical education: evidence for cross-cultural exchanges. Acad Med 2003;78:Suppl 10:S1-S5.
20. Jackson PW. Life in classrooms. New York: Holt, Rinehart & Winston, 1968.
21. Stern DT. Practicing what we preach? An analysis of the curriculum of values in medical education. Am J Med 1998;104:569-75.
22. *Idem.* In search of the informal curriculum: when and where professional values are taught. Acad Med 1998;73:Suppl 10:S28-S30.
23. Oxford English dictionary online. (Accessed September 29, 2006, at http://www.oed.com/.)
24. Stern DT. Can professionalism be taught? Virtual Mentor 2003;5(12). (Accessed September 29, 2006, at http://www.ama-assn.org/ama/pub/category/11716.html.)
25. Gracey CF, Haidet P, Branch WT, et al. Precepting humanism: strategies for fostering the human dimensions of care in ambulatory settings. Acad Med 2005;80:21-8.
26. Cote L, Leclere H. How clinical teachers perceive the doctor-patient relationship and themselves as role models. Acad Med 2000;75:1117-24.
27. Schön DA. Educating the reflective practitioner: toward a new design for teaching and learning in the professions. San Francisco: Jossey-Bass, 1987.
28. Branch WT Jr, Kern D, Haidet P, et al. The patient-physician relationship: teaching the human dimensions of care in clinical settings. JAMA 2001;286:1067-74.
29. Hensel WA, Rasco TL. Storytelling as a method for teaching values and attitudes. Acad Med 1992;67:500-4.
30. Hunter KM. Doctors' stories: the narrative structure of medical knowledge. Princeton, NJ: Princeton University Press, 1991.
31. Charon R. Narrative and medicine. N Engl J Med 2004;350:862-4.
32. Stern DT. The development of professional character in medical students. Hastings Cent Rep 2000;30:Suppl 4:S26-S29.
33. Sobel RK. Does laughter make good medicine? N Engl J Med 2006;354:1114-5.
34. Siegler M. Confidentiality in medicine — a decrepit concept. N Engl J Med 1982;307:1518-21.
35. Mizrahi T. Getting rid of patients: contradictions in the socialisation of internists to the doctor-patient relationship. Sociol Health Illn 1985;7:214-35.
36. Charap M. Reducing resident work hours: unproven assumptions and unforeseen outcomes. Ann Intern Med 2004;140:814-5.
37. Cohen JJ. Association of American Medical Colleges presidential address, November 10, 2002. (Accessed September 29, 2006, at http://www.aamc.org/newsroom/pressrel/2002/021110.htm.)
38. ACGME toolbox of assessment methods. Chicago: Accreditation Council for Graduate Medical Education, 2000. (Accessed September 29, 2006, at http://www.acgme.org/outcome/assess/toolbox.asp.)
39. Stern DT, ed. Measuring medical professionalism. New York: Oxford University Press, 2006.
40. Ginsburg S, Regehr G, Hatala R, et al. Context conflict, and resolution: a new

conceptual framework for evaluating professionalism. Acad Med 2000;75:Suppl 10: S6-S11.
41. Osborn E. Punishment: a story for medical educators. Acad Med 2000;75:241-4.
42. Hammond KW, Helbig ST, Benson CC, Brathwaite-Sketoe BM. Are electronic medical records trustworthy? Observations on copying, pasting and duplication. AMIA Annu Symp Proc 2003:269-73.
43. Alexander GC, Werner RM, Fagerlin A, Ubel PA. Support for physician deception of insurance companies among a sample of Philadelphia residents. Ann Intern Med 2003;138:472-5.
44. Eva KW, Rosenfeld J, Reiter HI, Norman GR. An admissions OSCE: the multiple mini-interview. Med Educ 2004;38: 314-26.
45. Stern DT, Frohna AZ, Gruppen LD. The prediction of professional behavior. Med Educ 2005;39:75-82.
46. Papadakis MA, Hodgson CS, Teherani A, Kohatsu ND. Unprofessional behavior in medical school is associated with subsequent disciplinary action by a state medical board. Acad Med 2004;79:244-9.
47. Papadakis MA, Teherani A, Banach MA, et al. Disciplinary action by medical boards and prior behavior in medical school. N Engl J Med 2005;353:2673-82.
48. Arnold L, Shue C, Kritt B, Ginsburg S, Stern DT. Medical students' views on peer assessment of professionalism. J Gen Intern Med 2005;20:819-24.
49. Hickson GB, Federspiel CF, Pichert JW, Miller CS, Gauld-Jaeger J, Bost P. Patient complaints and malpractice risk. JAMA 2002;287:2951-7.
50. MSPE: will it overcome challenges? AAMC Reporter. January 2006. (Accessed September 29, 2006, at http://www.aamc.org/newsroom/reporter/jan06/evaluation.htm.)
51. Papadakis MA. Do as I say, not as I do. Am J Med 1998;104:605-6.
52. Haidet P, Kelly A, Chou C. Characterizing the patient-centeredness of hidden curricula in medical schools: development and validation of a new measure. Acad Med 2005;80:44-50.
53. Burack JH, Irby DM, Carline JD, Rook RK, Larson EB. Teaching compassion and respect: attending physicians' responses to problematic behaviors. J Gen Intern Med 1999;14:49-55.
54. Srinivasan M, Litzelman DK, Seshadri R, et al. Developing an OSTE to address lapses in learners' professional behavior and an instrument to code educators' responses. Acad Med 2004;79:888-96.
55. Haidet P, Kelly PA, Bentley S, et al. Not the same everywhere: patient-centered learning environments at nine medical schools. J Gen Intern Med 2006;21:405-9.
56. Professionalism. Galveston: University of Texas Medical Branch, 2003. (Accessed September 29, 2006, at http://www.utmb.edu/professionalism.)
57. Institute of Medicine. Academic health centers: leading change in the 21st century. Washington, DC: National Academies Press, 2004.
58. Elnicki DM, Curry RH, Fagan M, et al. Medical students' perspectives on and responses to abuse during the internal medicine clerkship. Teach Learn Med 2002;14:92-7.
59. Core Committee, Institute for International Medical Education. Global minimum essential requirement in medical education. Med Teach 2002;24:130-5.
60. Cohen JJ. Preface. In: Stern DT, ed. Measuring medical professionalism. New York: Oxford University Press, 2006.