

The joy in caring

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Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.

—Dr. Francis W. Peabody
(AΩA, Harvard Medical School, 1906)¹

The joy in the care of the patient is in caring for the patient. Jack Coulehan, MD (AΩA, Emory University, 1974), wrote:

The rapid progress in medicine has indeed yielded an astonishing harvest of improvements in our patients' health...Medical practice provides a rich opportunity to experience empathy, hope, solidarity, compassion, and self-healing. Our profession gives us privileged access to deep bonds of humanity we share with our patients. Traditionally, physicians have considered this fulfillment one of the chief rewards of our profession.²

And, Sir William Osler said:

Nothing will sustain you more potently than the power to recognize in your humdrum routine...the poetry of the ordinary man, of the plain, toil-worn woman, with their loves and their joys, their sorrows, and their griefs.³

Medicine continues to make tremendous improvements in science, diagnostics, technology, and treatments, which clearly are better for patient care and outcomes. However, more physicians report dissatisfaction with the profession, and many report suffering from burnout. Perhaps all physicians who have given of themselves for their patients and society with empathy, hope, and compassion have wondered why they continue in the profession. For many, their focus on healing and caring can be met with frustration formed by an uncaring profit-driven system with myriad barriers. Some physicians may feel ignored, misunderstood, criticized, and devalued. However, nearly every physician has memories of the joy of medicine, caring for their patients, and one particular patient who reminds them of why they entered the profession of medicine.

Burnout is important to patients as well as to physicians and the profession of medicine. Job-related burnout

is characterized by emotional exhaustion, depersonalization (treating patients, students, and colleagues in a cynical way), and reduced feelings of work-related personal and professional accomplishment. It has been associated with reduced or poor job performance, clinical illness, cognitive impairment, mental errors, lack of attention and concentration, absenteeism, and thoughts of quitting or changing one's job and/or occupation. The total cost of recruiting a physician can be \$90,000, with the lost revenue for that physician between \$500,000 and \$1 million. Turnover begets more turnover, and those left behind are managing increased stress.⁴

It is estimated that more than 50 percent of physicians in the United States have at least one symptom of burnout.¹⁵ Typical symptoms include headaches, insomnia, tension, anger, and closed thinking. Symptoms of depression with altered mood, distorted behavior, and sleep disturbance can be experienced during extreme instances of burnout. Cognitive impairments in memory and attention can occur as well as behavioral effects associated with absences, time missed from work, and thoughts of quitting. The ICD-10 includes burnout under problems related to life-management difficulty with clinical manifestations similar to, and often consistent with, clinical depression.

A gratifying profession

I presented a lecture on hypertension to community physicians in the 1980s, and at the evening's dinner most of the older men were commiserating about the negative changes in medicine, medical care, hospitals, and patients. One younger woman was eating and not participating in the conversation, so I engaged her and asked what she thought about the current state of medicine. She was a 32-year-old obstetrician/gynecologist, and said, "You know, I don't remember the good old days. I am an excellent physician and surgeon, and provide excellent care for my patients. I have professional obligations to fulfill. I learned what form to complete, how to complete it, and how to negotiate the system on behalf of my patients. It is hard, but gratifying, and that's why I am a doctor."

Although burnout has probably existed for generations, the businessification and commercialization of medicine have brought it to the forefront for today's physicians. Medicine is now, and always has been, a demanding profession with immense responsibility to patients and society. However, as physicians, we must remember why we became physicians, why we care, and why we strive to "be worthy to serve the suffering."

Burnout and resilience

Burnout and a lack of resilience are often associated with stress. In 1997, Leiter and Maslach identified six major influences on burnout:

- Workload and its intensity, time demands, and complexity;
- Lack of control of establishing and following day-to-day priorities;
- Insufficient reward and the accompanying feelings of continually having to do more with less;
- The feeling of community in which relationships become impersonal, and teamwork is undermined;
- The absence of fairness in which trust, openness, and respect are not present; and/or
- Conflicting values, in which choices that are made by management often conflict with their mission and core values.⁵

Each of these influences are external to the individual, and typical of most medical environments today. Physician performance is often related to how many relative value units (RVUs) are billed, financial accomplishments to increase organizational revenue, and Press Ganey patient satisfaction survey scores. These performance factors are expected to be accomplished via reduced patient contact time, and diminished collegial interactions and consultation time, in an environment of demanding regulatory and legal requirements.

Little or no evaluation of care of the patient, patient outcomes, the doctor-patient relationship, medical professionalism, physician satisfaction and accomplishments are considered in the “business of medicine.” Physician output and success is often related to high volumes of work—RVUs, strict deadlines, an unyielding focus on technology, and the electronic health record (EHR). It is estimated that for every one hour spent with patients, nearly two hours are spent on the EHR, with another hour or two during personal time entering information in the EHR.⁴

Burnout can also be influenced by societal factors, individualized factors, a loss of support systems, changing values, and a lack of personal and/or professional recognition. While it is experienced by the individual, it can also affect coworkers, family, social networks, colleagues, and patients.

There are many screening tests used for burnout, but the most common and validated is the Maslach Burnout Inventory (MBI).⁶

The problems we are currently encountering that contribute to burnout were anticipated by sociologists who posed that bureaucratic and professional forms of

organizing work are fundamentally antagonistic.⁷ Medical schools have not yet prepared graduates as practitioners who can best resist the bureaucratic and market forces shaping health care and the care of the patient.

Burnout in medicine was anticipated by Relman’s concerns about the emergent medical industrial complex, and by Starr’s concerns about medicine’s sovereignty. Physicians experience conflict between what they aspire and should do, and what they have been educated and socialized to do. They have been professionalized for acquiescence, docility, and orthodoxy. They are taught to be more like sheep than cats—ultra-obedient following the rules. They are not taught to be cats—independent activists defending and advocating for medical values.

Bureaucracies are good at identifying and implementing common solutions to common problems; e.g., a profit and loss system based on consistent products with limited variability, but not very good in situations with variable contingencies and complexities as they attempt to apply standard solutions to non-standard circumstances. We have prepared physicians to follow the rules; however, whose rules? The rules generated by the profession? Or the rules generated by the organization with different values, and objectives?

As a result, physicians see professionalism more about conformity. This creates a conflict in the current health care system and organizations. Physicians seem to be perverting core principles of the profession to a just-follow-the-rules framing and practice of medical professionalism. We are essentially responsible for the problems we now encounter.

The impact of business, corporations, industry, markets, and finance for profit is real and appreciable. All these influence and exert pressure on how care is provided, and how work is carried out and valued. The rules are not being set by professionals, but by organizational priorities related to finances and the concept of profit. A professionalism that fails to dissect and distinguish itself from its two counterparts is a professionalism that is conformist and does not resist the pernicious elements of markets and bureaucracy.

We need cats who will resist conformity in service of extra-professional forces. The mission and resistance is about saving health care for patients and society, and enabling our profession and colleagues to care for patients and not face burnout.

Professional identity formation

The emphasis on professional identity formation resulted from the recognition by medical educators that an individual's identity begins to emerge at birth and proceeds in stages throughout life with the period beginning in the late teens and stretching into early adulthood being particularly important. The process of professional education in medicine is superimposed on this development, and has a profound impact on the identities that emerge.⁸⁻¹¹

Individuals, at a particularly formative stage of their lives, enter medical school with preexisting identities that have been shaped by both nature and nurture. Each of us is different based on our personal identity shaped throughout life by our experiences, role models, family, education, and reflection. During the long period of undergraduate and postgraduate education, each learner must come to terms with the norms of the community of practice that they are entering. These norms are outlined in the definition of profession and professionalism, as well as its list of characteristics and attributes.^{12,13} Each learner must cope with these norms. Many will be accepted outright, some will require compromises, and some norms may be rejected.

Through medical school, residency, and practice we have developed a new personal identity that was shaped by our prior pre-medical identity and our medical education and experiences. We started as medical novices and learned a new language of medicine, learned about basic and clinical science, developed clinical skills, and professional attitudes. Initially we learned from teachers, text books, lectures, laboratories, and simulations as we pretended to be doctors. We then advanced to mostly experiential learning from patients, colleagues, role models, and teachers, and received our certification as a doctor of medicine. We continued our learning and identity formation as residents and fellows, becoming experts in medicine and perhaps a specialty.

During this journey, we also developed as medical professionals with ethics and values basic to our profession. We became healers and medical professionals, and joined the community of practice of medicine as doctors/physicians. We retained much of our earlier personal identity, but combined it with our identity as a physician. We had our own models of reasoning.

We learned to construct small-scale mental models of reality to use in anticipating events, to reason, and explain things and events. We use deeply ingrained and internalized assumptions, generalizations, and images that influence our understanding of what we see, what

is happening, and how to take action. This organizes our lives, and provides options, direction, and guidance on how to deal with problems and get things done. However, this also reflects our developed biases.⁴ The major factors impacting identity formation in medicine are role models, mentors, and both clinical and nonclinical experiences. All have a profound impact and work through both conscious and unconscious mechanisms, leading to explicit and tacit knowledge. All are amenable to educational interventions that ensure a positive impact on identity formation, and are implemented in ways that are specific to the desired end result. Physicians should be individuals whose behavior is professional because of who they have become. One way to achieve this essential objective is to specifically design educational programs that support individuals as they develop the professional identity necessary for the practice of medicine, so that each practitioner has come to think, act, and feel like a physician. Seeley and Duguid said, "The central issue with learning is becoming a practitioner, not learning about practice."¹⁴

The hidden curriculum, lessons that are learned but not openly intended – transmission of norms, values, beliefs, and attitudes conveyed during learning experiences – teach unintended lessons that have an effect on professional and personal identity formation. These lessons may have a negative impact on the way a physician responds and reacts to difficult situations with which they are frequently confronted.

Social media can aggravate the hidden curriculum by embroiling students, physicians, and other health professionals in campaigns of backlash with an exponential number of adversaries. These social media interactions often contain strong opinions and inflame contentious issues thereby creating anger, antagonism, and hostilities. Mundane and theoretically non-contentious issues when brought into the work and/or personal environment can create highly volatile moral and emotional conflicts that are often unresolvable and can lead to burnout.

The development of a professional identity of a physician—how to think, act, perform, feel, and be a doctor—along with a well-defined set of expectations of the profession—The Physician Charter¹⁵—are the first steps toward resiliency.

Generational differences

Whether the situation involves work hours, social media, or digital devices, a shared understanding of professional comportment is essential. Generational differences

can lead to different interpretations of professionalism, and communication is the key to avoiding misunderstanding. Professionalism disconnects can arise from different personal and generational viewpoints, and can cause stressful situations for all involved. Professionalism can be contextual and situationally nuanced. Establishing safe spaces for direct communication and educating faculty and learners about the ways to communicate and navigate professionalism differences will help reduce the generational angst, allowing for healthy environments, and collegial teams.

Adhering to a medical professional code of conduct and values can create professional conflicts. Physicians often may need to develop “work arounds” on behalf of patients, and colleagues, in order to ensure the patient’s medical and personal necessities are fulfilled. Often, when a work around is needed, it is because what is best for the patient is lost in the superimposed, non-professional businessification of medicine. The physician and patient face the conflict and emotional consequences of doing the right thing for the patient while working around the systems and processes instituted to create a revenue-driven business model. Work arounds are undertaken so that the physician can continue to do what’s necessary to take care of patients, but often at a personal and professional toll; i.e., burnout.

Defining appropriate and inappropriate behaviors, reviewing expectations, encouraging and responding to questions, and establishing a shared understanding of rules and consequences provides safe environments, and can help reduce generational conflicts that can lead to burnout. Modeling professional behavior; being aware of inadvertent lapses in professionalism and acknowledging them when they occur; and communicating directly, in a timely way, and in an appropriate environment are crucial for older generations when communicating with students and new physicians who are neophytes in the profession.

In 1902, Osler told members of a medical society, “The times have changed, conditions of practice have altered and are altering rapidly, but...we find that the ideals which inspired [our predecessors] are ours today—ideals which are ever old, yet always fresh and new, and we can truly say in Kipling’s words:

The men bulk big on the old trail, our own trail, the out trail,
They’re god’s own guides on the Long Trail, the trail that is always new.”¹⁶

A community of practice

Physicians are part of a community of practice of healers and medical professionals. Over the last several decades, the medical community of practice has changed resulting in an isolated role for the physician with silos and unintended consequences.

Traditionally, physicians cared for patients in a clinical community setting where they consulted with each other regarding difficult patient cases and diagnoses, shared the joys and tragedies of medical care, and enjoyed a collegial relationship. Time required for the care of the patient was provided, and opportunities to learn and share experiences and knowledge were readily available. Physicians could teach and learn from each other, and from their patients. Social functions were organized for physicians, their families, and their medical community. They shared empathy, commiserated, and supported each other. With the advent of RVUs, and the commercialization and businessification of medicine, these communities of practice have diminished, and in many instances become extinct. In many cases, dialogue among colleagues is through email. Every order, every lab request and result must pass through this electronic portal, even if the person whose inbox you are about to overload is seated next to you.¹⁵

The re-establishment of medical communities of practice is one defense against burnout. Physicians need to have an opportunity to join a community of practice with other medical professionals who are educated and trained as healers.

In the community of practice I joined as an internist, we scheduled one-hour appointments for new patients and 30 minutes for follow up. If needed, I could schedule more time for a complex patient with special needs. We had a paper medical record that was only available for 50%–60% of visits. However, we knew our patients quite well. Most of the visit was directly involved with the patient – no computer screen. We took notes on the history or examination, and handwrote the clinical notes in the patient’s record during or after the patient visit. We completed documents of the visit with diagnoses and level of service, largely without awareness of associated relative value units. We checked boxes on a single page to order tests, referrals, follow up, etc.

The clinic library was small and limited with no online resources. Between patients we would go to the corridor, conference room, or charting room to have a conversation with colleagues, team members, and staff. Sometimes we commiserated about problems, barriers, or system limitations, but often we would take joy in the care of the patient

by presenting a great case and sharing what we had done and learned. We had an opportunity to discuss difficult cases, share reasoning, and learn from a colleague.

These short intervals were collegial and provided an opportunity for education and reflection. On Fridays, before going home we would often share a short “Thank God It’s Friday” event to share stories from the week. Once a week, we would have organized clinical practice teaching conferences. Once a month, we would organize an evening together with colleagues, spouses, and significant others to socialize. We often went to the gym with colleagues to workout, and had organized recreational sports teams. At least twice a year we would have an entire group social event with families for an afternoon picnic or evening dinner. Many of these events were open to other specialties so that we would have an opportunity for cross-discipline collegiality.

This was our community of practice.

In medicine today, patients are scheduled for 30 minute to 40 minute new patient visits, and 15 minute to 20 minute follow-up visits. Patient visits are booked from 8 a.m. to 5 p.m., Monday through Friday. There may be a scheduled lunch break though it is often used to catch up when extended patient visits muddle the schedule. Physicians have no flexibility in allocating time dependent on patient complexity, and other needs of the patients. Today, more than one-half of each patient visit is spent facing a computer screen. There is no time allocated to reflecting on the joy of caring for the patient, or sharing that joy with colleagues for educational purposes. There is no time between patients to share or commiserate.

When time permits, which is infrequent, sharing joys and complaints with colleagues, students, or residents is done with antipathy by those suffering burnout. This creates self-doubt, stress, and unhappiness. Reflection is often on too many bureaucratic tasks; too many hours at work; a lack of respect; problems with the electronic health record; a lack of control; no autonomy; an emphasis on profits and revenue over patients and care giving; administrative burdens; a lack of professionalism; and/or a lack of collegiality.

Colleagues may not know others within the practice, and seldom know physicians in other disciplines. There may be few community of practice social events.

All of this contributes to physician burnout and depression when the joy of caring, and learning and teaching, are diminished or lost. This is a tragedy for our profession, and for the care of patients.

Medical professionalism

Medical professionalism should strive to achieve a level of caring in which service transcends self-interests. By achieving this level of caring, physicians can care for individual patients, and also for the greater good. The ability to focus outward and attain great joy from caring for others will overcome the feelings of burnout.

Bureaucratic and market forces will continue to battle for the hearts and minds of 21st century professionals essentially unopposed by the ethos, ethics, and practice of professionalism. In the end, none of this is about saving the world for professionals; rather it is about saving health care for patients and the public in a world where mission increasingly is defined in terms of margins.

Medical educators and leaders of health systems have enormous opportunities to shape the professional development of learners, thereby reducing the propensity to burnout. It is crucial to identify and build sustainable models to ensure that learners and new physicians are exposed to positive role models, and introduced to how professionals self-regulate, and why. Curricula and experiential learning approaches are unlikely to have a lasting impact if organizations fail to put in place the right people, processes, and technology to address unprofessional behaviors among senior team members, as well as learners.

We accept our mental models as external reality or truth, and we act since it makes sense to us and our identity. Our thinking, behaviors, actions, and performance are all affected by our way of thinking and being derived from our personal and professional identity. We do what makes sense to us. We usually don’t realize and recognize that it is our unique construct of reality for us.¹⁷

This often results in selective perceptions. We have stored in our memories those experiences we ascribe meaning to because of positive or negative feelings that were evoked when they happened. They tell us a constructed story, not necessarily a true story. We consult our story, consciously or unconsciously, in everything we do and experience with easy-to-recall “interpretation-based” truths that inform our thinking and determine our choices and behaviors. These storied interpretations question our work, competence, professionalism, adequacy, and acceptance. This translates into a belief that says, “I am not good enough,” or someone or something external is to blame. Analysis, sense-making, and interpretation of inputs are always after the fact and represent hindsight. In cases of not so pleasant or unpleasant, difficult experiences, our interpretation is invariably different from what really happened or is happening.

Our cognitive mental associations affect how we perceive and act, are generated implicitly or unconsciously, and are the source of how we perceive events and develop thoughts and responses. We develop ways of responding that are often biased, and become habitual cognitive responses and beliefs of which we are not even aware. These habitual unconscious thoughts often create our inner voice that speaks with negative thoughts and beliefs, and creates stress and misconceptions.

Conscious cognition processing allows us to think, respond, and make decisions requiring concentration and thoughtfulness, effort, and deliberate concentration.

Because of time pressure, fatigue, stress, and information overload, physicians' cognition is impacted, and they often use unconscious cognition to make sense of experiences in work and life. This results in implicit responses that are not helpful, and can create negative or non-valid thoughts and perceptions.

After a 20-minute visit with a patient, unconscious cognition might be telling you that you are not good enough for this job and the responsibility. In contrast, thoughtfulness and conscious cognition might conclude that the patient is really suffering, and while it is difficult with only 20 minutes to learn and understand from her, her medications are helping her and you can make her life better by refilling the prescriptions for her chronic condition. These cognitive inputs shape attitude and beliefs.

We all have empowering and disempowering stories in our memories which, when positive, are powerful and are useful for living our lives and doing our work. However, when they are unhealthy dysfunctional stories and memories, they hold us back. These negative chapters in our life stories that question our competence and adequacy create doubt, and unhappiness, and we may become defensive, controlling, manipulative, judgmental, and/or disrespectful, with behaviors that are dysfunctional and/or negative. This, coupled with stress, results in emotional turmoil and negative responses and may lead to burnout.

Resilience is the ability to consciously rethink the story and interpretation of what happened, or is happening, and reshape it to an empowering life story. Our inner voice must remind us, "I have much to be grateful for; the work I do makes contributions to others; my caring makes a difference to me and my patients; I am worthy to serve the suffering; I am part of something larger than myself; I appreciate what others do for me; I seek out the best in others; I commit to professional behaviors; I will work to heal and care for others and be a responsible member of my profession and community of practice; I will work

positively to contribute to changes that will support the best care for our patients."

Resiliency

Burnout is a common problem for physicians. They need to self-evaluate, and watch for signs in themselves and their colleagues. Self-reflection and honesty are useful in self-evaluation. Commitment to work, self-efficacy, learned resourcefulness, and hope may help with resiliency, and increased job control.

Cognitive-behavioral therapy improves coping and mental health by development of personal coping strategies that target solving problems and changing unhelpful patterns in thoughts, beliefs, attitudes, behaviors, and emotional regulation. This uses mindfulness-based approaches and therapies that are problem focused and oriented to actions that are helpful in treatment and prevention.

Distortions and maladaptive behaviors can be reduced by learning processing skills and coping mechanisms. This helps by challenging patterns and beliefs to utilize new ways of mindfulness and conscious thinking. Replacing magnified negatives by thinking more positively and optimistically with realistic and effective thoughts can help return the joy of caring for patients, while at the same time coping with the systems and barriers. This is a way to become more open, mindful, and aware of cognitive distortions, and can lead to the ability to think differently. It replaces the maladaptive cognition, coping, emotions and behaviors with adaptive successful ones.

While physicians and their colleagues can learn to cope with dysfunctional health care systems that don't truly value the patient and the care of the patient, the only way to truly prevent and enable physicians to care for patients and avoid burnout and dysfunction in practice is with organizational change and reinstatement of the community of practice. Medical organizations need to re-evaluate the care of the patient and the needs of the patient and physician. Physicians and organizations must collaboratively create and support a culture of caring that emphasizes compassion, respect, values, and principles to serve the suffering. This will allow physicians and the care teams to be committed.

Organizational change includes realistic workloads and supportive systems. This means encouraging mentoring and mentors, recognizing role models, providing control for those providing the care, compassion, and appreciation. This is the heart of medicine's contract with society.

Organizations must recognize that the care of the whole patient is more than a commodity or a business. Caring

for a patient and the well-being of the physician is more than RVUs. They must eliminate barriers and decrease administrative burdens.

The care of the patient is more than understanding and treatment of disease. Health care systems and physicians must be prepared and supported to address the needs of the whole patient as a person. Professionalism combined with the ethics of doing the right thing for the right reason, and a commitment to reflection and evaluation of what is being done and why it is being done are paramount to the success of our health care system. There must be a preparatory culture of caring in teaching and learning.

We must create and nourish a new community of practice in medicine with greater collegiality and support. These must be mindful organizations that create opportunities and responsibility to meet and have conversations about the virtues and challenges of being a physician and providing care for the whole person.

All of this will require that physicians demonstrate and exert leadership. For example, organize a retreat of the physician practice and team to discuss how to develop a community of practice, including teaching and learning activities, social and family events, celebratory recognition ceremonies, opportunities to tell stories, and time to commiserate.

Caring and providing for patients also involves caring for each other and our profession, and contributing even more to the community in which we work and live. When the organization and system do not enable us to care for our patients and colleagues, we must be assertive to demand application of our ethics and values in the care of our patients.

Resiliency begins with changing our thinking and opening the door to constructive change and finding the joy in caring for patients. Don't allow burnout to take over your professional life. Find who you really are as a physician and medical professional. Know you are the one who makes authentic commitments and helps others. Be the one who improves the human condition. Move your work, life, and community forward. Be worthy to serve the suffering.

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