

The Utility of Reflective Writing after a Palliative Care Experience: Can We Assess Medical Students' Professionalism?

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Abstract

Background: Medical education leaders have called for a curriculum that proactively teaches knowledge, skills, and attitudes required for professional practice and have identified professionalism as a competency domain for medical students. Exposure to palliative care (PC), an often deeply moving clinical experience, is an optimal trigger for rich student reflection, and students' reflective writings can be explored for professional attitudes.

Objective: Our aim was to evaluate the merit of using student reflective writing about a PC clinical experience to teach and assess professionalism.

Methods: After a PC patient visit, students wrote a brief reflective essay. We explored qualitatively if/how evidence of students' professionalism was reflected in their writing. Five essays were randomly chosen to develop a preliminary thematic structure, which then guided analysis of 30 additional, randomly chosen essays. Analysts coded transcripts independently, then collaboratively, developed thematic categories, and selected illustrative quotes for each theme and subtheme.

Results: Essays revealed content reflecting more rich information about students' progress toward achieving two professionalism competencies (demonstrating awareness of one's own perspectives and biases; demonstrating caring, compassion, empathy, and respect) than two others (displaying self-awareness of performance; recognizing and taking actions to correct deficiencies in one's own behavior, knowledge, and skill).

Conclusions: Professional attitudes were evident in all essays. The essays had limited use for formal summative assessment of professionalism competencies. However, given the increasing presence of PC clinical experiences at medical schools nationwide, we believe this assessment strategy for professionalism has merit and deserves further investigation.

"The problem is that physicians are searching for professionalism in the wrong place. It is not found in the lists of qualities. It is found in the quiet moment in which the physician reflects upon the day's occurrences. The successful curriculum in professionalism guides and provides for reflection."¹

Introduction

PROFESSIONALISM IS A COMPETENCY DOMAIN that must be mastered for graduation from medical school. The Association of American Medical Colleges (AAMC) has defined professionalism as the "ability to understand the nature of, and demonstrate professional and ethical behavior in, the act of medical care."² Among other virtues and skills, profes-

sionalism includes respect, altruism, cultural competency, caring and compassion, and confidentiality. Although the AAMC recommends specific objectives for teaching professionalism, for example, "expressing sensitivity to others' circumstances,"² they do not proscribe how to teach professionalism, or how to objectively evaluate student competency.

The scientific literature provides abundant examples of medical school curricula that employ didactic, ceremonial, and role-modeling strategies to teach the knowledge and skills of professionalism.³⁻⁶ However, professional attitudes are more problematic. The affective domain traditionally receives less attention than the cognitive domain in medical education, even though motivation is necessary for learning.⁷

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Reflective writing is increasingly integrated into medical school and residency curricula.⁸⁻²¹ Many have described storytelling and reflective writing as methods to both teach and evaluate professional attitudes.^{10,14,15,18,22-27} Educational activities that include learner opportunities to gain perspective, time for reflection, and mentoring are successful strategies that work in teaching humanism²⁸ and empathy,^{26,27,29-32} part of professionalism.

Professionalism is a core competency and foundation for palliative care (PC) as a field.³³ PC aims to optimize quality of life for seriously ill patients and their families. The goal is to provide symptom management and an extra layer of support addressing communication, spiritual, emotional, and social realms. Professionalism and PC domains overlap significantly around caring and compassion, the human connection arising around mortality, and clinician self-care. We posit that a clinical PC experience, due to the often deeply moving and challenging interaction with a dying person, is a powerful trigger for reflection and thus also an ideal venue for teaching components of professionalism. We further posit that reflective writing after such an experience offers a unique opportunity to uncover evidence of professional attitudes and behaviors.

Effective professionalism assessment requires multimodal summative and formative measures; no single measure is adequate. High-stakes teaching strategies utilizing standardized patients or simulation to assess professionalism may produce spurious results if students respond as they "should" rather than as they "would." Formative measures using reflective writing, critical incidents, and longitudinal observation help to benchmark and mold professional identity along with the reasoning that guides future behaviors. Yet formative measures that reveal attitudes that do not correspond to behaviors are suspect (a student might acknowledge the value of sitting down with a patient to deliver difficult news in an essay but not do this in practice).

Nonetheless, reflective writing has the potential to challenge the way we think and give the learner an opportunity to review an approach, consider the meaning involved, or just express and process his/her emotions. Reflective writing as an educational strategy provides a framework for self-examination and reinforcement of the clinical learning experience "reconstructing the world."³⁴ Although not a perfect method to assess professionalism, reflective writing is the most frequently supported by medical educators.

The purpose of this qualitative study was to evaluate the merit of using students' PC reflective writing as a teaching strategy for select professionalism objectives and as an assessment tool for professionalism competency.

Methods

All third-year medical students (MS3s) at Baylor College of Medicine (BCM) participate in the Longitudinal Ambulatory Care Experience (LACE). This year-long course has included a required PC experience since 2007; course details are reported elsewhere.³⁵ A 3-hour PC workshop begins the year with a didactic portion on basic PC concepts, a faculty-guided interview with family members of deceased patients who received PC, and a small group session with faculty facilitation. All students then engage in one scheduled half-day clinical PC patient experience and complete an online pain management module before the end of the academic year.

PC patient experience

Students visit one of eight community hospice or in-hospital PC sites supervised by a board-certified hospice and palliative medicine physician. Visits begin with a site orientation and brief review of PC domains. Working in pairs, the students are assigned to a preselected patient or family member (in the case of a nonverbal patient). Students interview the patient or family with intermittent faculty supervision for about an hour. A standardized PC history and physical form provides content guidance for the interaction. Afterwards, students present to the supervising physician for group discussion and debriefing. Faculty focus on clinical teaching points and explore students' thoughts and feelings about the patient interaction and overall experience. Students then complete a required one-page reflective essay within a week (see Table 1 for essay instructions). Students were not explicitly asked about professionalism.

Sample

Essays were collected in two academic years (2007–2009). To prepare a preliminary thematic coding structure, we randomly sampled five essays from the 2007–2008 academic year. We then drew three more random samples of 10 essays ($n=30$) from the 2008–2009 cohort to serve as our sample for the primary qualitative analysis, after which we achieved thematic saturation.

The analyst team consisted of two PC physicians board-certified in geriatrics and internal medicine, a medical educator with nursing and public health expertise, and a research scientist with background in psychology and qualitative methods.

Analysis

In 2004, BCM identified 11 professionalism core competencies graduating students are expected to achieve.³⁶ As shown in Table 2, we selected four of them that seemed most relevant to the PC curriculum. These included 1) demonstrating caring, compassion, empathy, and respect; 2) demonstrating awareness of one's own perspectives and biases; 3) displaying self-awareness and dedication to continual improvement; and 4) recognizing and taking actions to correct one's deficiencies. We felt these four could be robustly explored in students' reflective essays and expected each to be represented therein.

We used a standardized approach to qualitative thematic analysis, including direct coding of content with iterative

TABLE 1. STUDENTS' INSTRUCTIONS FOR WRITING THEIR REFLECTION

1. Describe your thoughts and feelings about caring for a dying patient BEFORE your LACE palliative care visit. Describe any changes in your thoughts and feelings afterwards.
2. During the visit, to what degree were you able to have compassion for the patient and/or family?
3. What was the most challenging characteristic of the patient and/or family for you? Why was it a challenge?
4. What did you learn from this experience that you can use to enhance your relationship with patients in the future?

Instructions developed by authors (AG and LM).

TABLE 2. PROFESSIONALISM COMPETENCIES THAT WERE ASSESSED DURING QUALITATIVE ANALYSIS

1. <i>Demonstrate caring, compassion, empathy, and respect.</i> Communicates in a polite tone and manner in all exchanges and encounters. Sensitive to the emotional needs of others.
2. <i>Demonstrate awareness of one's own perspectives and biases.</i> Takes action to identify conscious and nonconscious bias that may impact interactions with patients and others. Interested and attentive to perspectives and cultural beliefs of others.
3. <i>Display self-awareness of performance and dedication to excellence by continual improvement of knowledge, skills, and attitudes.</i> Identifies status of competency achievement. Plans with assistance (as needed) and implements course of improvement.
4. <i>Recognize and take actions to correct deficiencies in one's own behavior, knowledge, and skill.</i> Self-assess progress and requests feedback. Acknowledges, reflects upon, and takes action in response to feedback for improvement.

Four competencies were selected from Baylor College of Medicine's catalogue of 11 medical student professionalism competencies.

review, to explore these competencies in depth. For each, we examined the nature of and extent to which students' professional attitudes were reflected in their writing about their PC experiences. First, each analyst independently read the five 2007–2008 randomly sampled essays four times. Each "reading" focused on only one of the competencies that framed our analysis; the analyst recorded emergent themes related to each competency. All analysts then met face-to-face to discuss these emergent themes, consider analyst differences in coding, and finalize a preliminary thematic structure. This served as the coding structure for the primary analysis of the 2008–2009 data, though new themes were added to the structure if and as they emerged.

As a second step, we conducted our initial (or "first cycle") coding to identify themes within each competency.³⁷ Using the first random sample of 10 essays from the 2008–2009 cohort, analysts coded each essay, noting a) extent to which the identified themes corresponded to thematic structure previously developed, b) any superb (i.e., "highly illustrative") exemplars of themes, and c) any emergent themes not previously captured. Analysts identified meaningful sections of text in each essay ("quotes") that represented the professionalism themes in the essay, and coded the quote with the appropriate code. Analysts could provide more than one kind of code to the essays overall, because essays could reflect multiple professionalism themes. The team of analysts then met again face-to-face to discuss their coding. This process was repeated for two additional samples of 10 essays each (total number of essays $n=30$), at which time thematic saturation was achieved. We used ATLAS.ti (ATLAS.ti, version 6.2; Berlin, Scientific Software Development GmbH 2011), a qualitative software package for data coding and management, and approached the data using a combined thematic and content analysis approach across the two stages.

As a third step, we compiled preliminary reports from ATLAS.ti regarding the frequency of theme use within and across each competency, possible interrelationships between

themes and competencies, and high-priority exemplars, which served as the foundation for our "second cycle" coding to synthesize the information to date. Using the quotes coded earlier within each essay, we identified which codes were present in each essay to assess frequency of codes across essays. The team met several more times to discuss the final thematic structure, interrelationships and exemplars, and to explore how the final results answered the research question.

Results

The 30 essays produced 176 coded quotes. Essays revealed many examples of rich text suggesting students' progress toward achieving the first three professionalism competencies developed by BCM; that is, 27.8% of all quotes were coded as related to competency 1, 31.8% as related to competency 2, and 23.9% as related to competency 3, respectively. In contrast, only 16.4% of text was coded as related to professionalism competency 4. Further, emerging themes for competencies 1 and 2 tended to be more rich and detailed than those emerging for competencies 3 and 4.

For competency 1, subthemes included a) expression of compassion for patients/families, b) expression of emotion, including embarrassment and inner conflict, and c) respect for the patient and family as teacher. For example, a student expressed compassion for the patient and the struggle with wishing to please the patient while remaining honest:

"The most challenging characteristic of the patient was his denial of the futility of further medical care, and lack of insight into his situation. It was difficult to be honest with him, while at the same time being sensitive to his peace of mind and trying not to needlessly upset him. When I was saying goodbye and thanking him for the conversation, he expressed his belief that I was a new doctor that had come to tell him some news, because all the other doctors had given up on him. Although I wanted desperately to lie just so he could be happy, I tried to gently explain who I was; the disappointment on his face was gut-wrenching." (Essay #8)

Another student reflected on how the patient's and family's demeanors made an impression and made learning easier:

"Both she and her husband were at peace with their decision for hospice care, and their calm, accepting attitude made it much easier for me and the other student to perform the palliative care assessment, to have compassion for them and to understand how patients make such a difficult decision and make peace with it." (#7)

Table 3 shows further illustrative quotes for these subthemes.

Regarding competency 2, students described expectations about PC prior to the visit which corresponded to their (dis)comfort level in their potential role of caring for dying patients/their families, see Table 3. They often described how these expectations differed from reality. Many expressed how they had perceived being a failure as a physician if they had to send a patient to hospice and how this view changed after their PC experience:

"Also, as a medical professional, in some ways to address the subject of death seems to be equivalent to giving up." [...] "My visit to this palliative care site confirmed for me that caring for dying patients is challenging, but it did change my views somewhat on the concept of discussing death as essentially admitting failure" (#8), or:

"The patients that I had seen who had terminal illnesses or irreversible diseases, I never really gave too much thought about how my approach to their care would change as they neared the end of their

TABLE 3. ILLUSTRATIVE QUOTES FOR THE RESPECTIVE PROFESSIONALISM COMPETENCIES

<i>Professionalism competency</i>	<i>Subthemes</i>
1. Demonstrate caring, compassion, empathy, and respect.	<p data-bbox="467 1266 488 1524"><i>Expression of compassion:</i></p> <p data-bbox="492 170 540 1524">"To feel anything but compassion for a person walking hand-in-hand with death is inhuman... It is one of the many realities of medicine... The cure is not always in a bottle or on an operating table." (essay #28)</p> <p data-bbox="544 88 592 1524">"My most poignant memory was her statement: "Cancer doesn't have me—I have cancer." Not only was she taking ownership of her life, but she was also taking ownership of the very disease that would end her life and this moved me." (#13)</p> <p data-bbox="596 905 617 1524"><i>Expression of emotion, including embarrassment/inner conflict:</i></p> <p data-bbox="620 88 669 1524">"I felt emotional when the patient described the conversation in which she decided to stop all treatments and seek hospice care. It was also hard to hear her say that her husband tells her everyday how much he will miss her." (#16)</p> <p data-bbox="672 88 786 1524">"I was present during discussions on changing his code status... and felt uncomfortable because it seemed the team was giving up on him... I felt conflicted... because I wanted so much to help him, but as a part of the team, I knew that hospice was the best we could offer him to improve the quality of the time he had left. It almost seemed like I had to choose between being my patient's advocate and being 'loyal' to my team." (#7)</p> <p data-bbox="789 709 813 1524">"I thought crying would be unprofessional or improper in some way." (#22)</p> <p data-bbox="816 275 841 1524">"I wanted to know what her plans were, her hopes and dreams... but I never asked. I didn't have the courage." (#23)</p> <p data-bbox="844 88 893 1524">"It was very difficult for me to approach the subject of death with someone who was so eager to live. I remember feeling utterly hopeless and at a loss for words." (#25)</p> <p data-bbox="896 1142 920 1524"><i>Respect for patient/family as a teacher:</i></p> <p data-bbox="924 88 989 1524">"She was gracefully accepting her inevitable death and living the last of her life as best she could... I felt comforted being around her, even though as physicians in training we are supposed to be the ones providing comfort. Her grace put me at ease." (#22)</p> <p data-bbox="992 88 1057 1524">"When asked about what he was afraid of, he replied 'the unknown.' I was struck by the insight behind this response, because despite what anyone believes, no one truly knows what lies beyond death. Instead of dwelling in fear of the unknown, this patient made it a point to live one day at a time." (#25)</p> <p data-bbox="1060 88 1109 1524">"I really appreciated the patient I was able to visit with... She gave us good advice as to how we can be better doctors in the future. She made it easy to see what she and her family are going through." (#12)</p> <p data-bbox="1112 88 1161 1524">"The family's devotion to the patient, staying at bedside, despite his medical problems due to his self-destructive behavior showed the forgiveness and the unconditional love a family carries for one of its members." (#15)</p> <p data-bbox="1164 646 1188 1524"><i>Often a description of expectations about palliative care, compared with reality (postvisit):</i></p> <p data-bbox="1192 88 1256 1524">"I imagined a depressing place... I imagined people either in pain, emotional or physical, or those who were heavily sedated with strong narcotics. During my visit I was surprised how comfortable the hospice environment seemed." (#24)</p> <p data-bbox="1260 499 1284 1524">"Prior to the palliative care experience, I had not given dying patients any thought." (#s13 & 20)</p> <p data-bbox="1287 88 1336 1524">"I suppose that I pictured the role of a physician caring for a dying patient to be one of two things: either fighting until the end or determining that care was futile and allowing the patient to pass in front of their eyes." (#9)</p> <p data-bbox="1339 302 1364 1524">"I assumed that discussions with patients regarding death and dying would be by definition heartbreaking." (#21)</p> <p data-bbox="1367 88 1416 1524">"I suppose I thought of it more as waiting around for something to happen, but it appears hospice care is a very active and engaging process." (#16)</p>
2. Demonstrate awareness of one's own perspectives and biases.	<i>(continued)</i>

TABLE 3. (CONTINUED)

Professionalism competency	Subthemes
3. Display self-awareness of performance and dedication to improvement of knowledge, skills, and attitudes.	<p>"Initially my thoughts and feelings about caring for a dying patient included those of we can no longer do anything for this patient." (#1)</p> <p>"To do this well, I believe that you must have a good idea of how you feel about your own death and consider the challenges and emotions you will go through in order to be able to relate better with the patient." (#26)</p> <p>"I felt conflicted as well, because I wanted so much to help him, but as a part of the team, I knew that hospice was the best we could offer him to improve the quality of the time he had left. It almost seemed like I had to choose between being my patient's advocate and being 'loyal' to my team." (#7)</p> <p>"As soon as this concept is mentioned, the patient, family as well as the primary physician, become anxious because of the feelings it brings about. For the patient and family it is something that signifies that the patient is dying and for the physician it brings about feelings of failure, as they no longer can strive for a cure." (#1)</p> <p><i>Students often focused on their awareness of fear in working with the dying, especially due to not knowing how to communicate well:</i></p> <p>"Therefore, having never really experienced a dying patient, I have actually been terrified about having to deal with one." (#3)</p> <p>"I did not know how to phrase the question in a sensitive, appropriate manner." (#10)</p> <p>"The patient was still hoping for another doctor to come and fix him; it was difficult to listen to him.[because] the hope in his voice was unmistakable and heartbreaking." (#8)</p> <p>"Being exposed for the first time to difficult, emotionally charged issues, I find it challenging to know exactly how to approach patients with the appropriate balance of compassion and respect while still exploring these issues." (#10)</p> <p>"I expected some challenging, awkward moments during the interview, but the patient/family placed me at ease. She was easy to talk to and so comfortable with her situation that talking about death was surprisingly much easier than expected." (#7)</p>
4. Recognize and take actions to correct deficiencies in one's own behavior, knowledge, and skill.	<p><i>Themes quite often reflected more "lessons learned" rather than specific, concrete actions:</i></p> <p>"I still feel uncomfortable with death...but I think I grew just a little more as a medical student and more importantly, as a human being." (#23)</p> <p>"I realized it was ok to show emotion in front of your patients and even cry, so long as your feelings are genuine.[...] I learned that showing patients how much you care, even if you cry, is important." (#22)</p> <p>"A dying patient is not a failure on part of the team; the patient told us that. Rather, the team that fails the patient is the one that is not honest and does not put their heart and soul into the patient." (#29)</p> <p>"I learned that patients may oscillate between feelings of acceptance and denial toward death. Also, patients are not always looking for a cure, instead many terminally ill patients desire symptom management, and it is very important to make them as comfortable as possible." (#25)</p> <p>"I think this experience will help me possibly to engage patients with poor prognosis more in terms of their family and how they want to live their remaining time." (#16)</p> <p>"This experience has taught me to explore the family dynamics and communication earlier in the conversation with a dying patient." (#18)</p>

lives. I guess it's something that always scared me because in that position you kind of feel that you've failed as a physician. Doctors always want to 'fix' their patient's, and when a patient is at the point where palliative care is the only thing left, you feel like you're not doing your job correctly." (#12)

For the third competency, subthemes focused on awareness of the students' fear in working with the dying, and in particular not knowing how to communicate well, for example: *"I realized I was so scared to bring up the future for fear of asking her to utter anything about her own mortality"* (#23).

For competency 4, students predominantly reflected on "lessons learned" rather than specific future actions. *"I also learned that one does not have to fulfill a distant role to remain professional"* (#30). However, many indicated that their inner conflict of communicating with dying patients lessened after their PC experience, for example: *"I learned that the dying patient is often more comfortable with his or her impending death than the physician might be and thus often wants frank and open discussions about their death, and plans to be made"* (#15); see Table 3.

The selected competencies and representative quotes should not be seen as "silos"; quotes often crossed several competencies. Students frequently mixed statements of empathy or respect for their patients with comments on their awareness of their biases, and expressions of self-awareness of performance and dedication to excellence were mixed with thoughts on how to improve or on "lessons learned."

Although all 30 essays showed evidence of at least one of the competencies, 28 (93.3%) showed evidence of competency 2. Evidence of the other competencies was slightly less frequent in the essays; 24 (80.0%) showed evidence of competency 1, 23 (76.7%) of competency 3, and 21 (70.0%) of competency 4.

Discussion

We found a clinical PC experience to be an effective trigger for reflection among our students. This is not surprising given the potential emotional content and challenges encountered by clinicians providing PC. Indeed, self-reflection and demonstration of self-care practices are components of the professionalism subcompetencies for subspecialist training in hospice and palliative medicine.³⁴ Further, Weissman et al. posited that PC curricula for medical students in clinical rotations should include reflective time to allow for self-awareness of emotional responses to these experiences.³⁸ The literature supports this trend with examples of recently implemented medical student PC curricula incorporating reflective essays.^{39–43} These publications highlight the powerful impressions and important lessons students wrote about,^{39,40} and report student themes focused on what was learned, including about themselves, the patient, and being a doctor, and what was experienced, including internal emotional responses and self-transformation.⁴¹ These authors however, did not use the specific lens of professionalism to analyze their essay data.

Not only does a clinical PC experience lend itself to reflective practice and writing, it may be an efficient way to teach and assess professionalism. We believe ours is the first article to examine reflective writing after a clinical PC experience as a way to assess professionalism. Assessing professionalism requires a discord in principles for the learner to identify the conflict, the resolution, and the reasoning.⁴⁴ Be-

cause the exigencies of clinical practice are uncertain, finding such conflicts in principles for students to encounter on a consistent basis is difficult. Meeting educational objectives around professionalism requires more than assigning students to clinical rotations and hoping these specific teaching opportunities arise. Clinical PC experiences seem to be one means of overcoming this barrier and meeting educational objectives for professionalism on a more consistent basis, especially as more medical schools integrate clinical PC experiences. Professional attitudes related to all four selected professionalism competencies were evident in the student essays. Our essay instructions represent the format developed to guide student reflection for the clinical PC experience. The balance between fewer prompts to allow for spontaneous themes and more proscription to guide reflection toward exploration of potential conflicts is a challenge. Reflection should include a significant element of freedom to encourage depth of thought and personal insight; however, an open narrative format is less predictable and probably best serves a formative assessment approach. On the other hand, more specific prompts linked to different professionalism competencies might yield a summative assessment. As currently constructed, the essays have limited use for summative assessment; this might be mitigated some in the future by more specific essay prompts. The essays do offer opportunities for formative assessment of professionalism, which ultimately may contribute to the development of professional identity. Because achieving a summative assessment of professionalism may be the greater challenge in the larger medical school curriculum and true formative feedback on an essay is difficult to achieve in real time, we favor an adjustment toward a more summative assessment for our future essay instructions.

Limitations

Reflective writing as a teaching and assessment strategy has inherent limitations. First, student essays are self-report, not observed, and thus, not readily verifiable in terms of content and meaning. In addition, students choose and frame the content they do reveal through writing. Therefore, lack of depth or insight in an essay does not directly imply that a student did not experience professional growth during the experience. Again, although more suggestive of professional growth, depth and insight in an essay do not directly translate to more professional behaviors. Differences in writing ability are another potential limitation. Different skill levels may impact students' ability to effectively communicate or express the impact of their learning experience. However, a study that examined students' reflections on professionalism for writing and storytelling ability found reflection to be a distinct skill not affected by students' writing ability.²⁵ Thus, writing ability seems a less important consideration here. Some might consider giving students prompts for writing their essays as too narrowly focusing their potential reactions to the PC experience. However, from informal feedback, many students appreciated some guidance for structuring their essays. The assigned value of a reflective essay as low stakes or high stakes may also affect the quality and content of what is expressed by a student. In our study, the reflective essay was a low-stakes, ungraded check-off item; thus, the professionalism themes identified may be viewed as even more impressive.

Last, we noted in our analysis that the quality of students' experiences sometimes differed by types of patients interviewed (e.g., verbal versus nonverbal), and this variation could have influenced the depth and intensity of their learning experience. Although family members were present for visits with nonverbal patients, the quality and emotional impact of a direct patient interaction is sometimes hard to substitute.

Conclusion

PC training is an optimal venue for reflective writing. We found a clinical PC experience to be a powerful trigger for reflective writing and a potentially effective way to teach and assess professionalism. Professional attitudes were evident in all student essays and possibly reinforced through the reflective writing exercise. As currently constructed, the essays have limited use for formal summative assessment of the professionalism competencies. With further adjustment to the essay instructions, this might be better addressed. The essays do offer opportunities for *formative* assessment of professionalism, and ultimately, the development of professional identity. Given the increasing presence of clinical PC experiences at medical schools, we believe this assessment strategy for professionalism has merit, the potential to be very effective, and deserves further investigation.

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