20 Teaching, Learning and Assessing Professionalism at the Post Graduate Level

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Executive Summary

However professionalism is defined, embedded in the meaning of the word are those characteristics that lie at the heart of the doctor-patient relationship, and that traditionally have been associated with the role of the healer in society: caring and compassion, insight, openness, respect for patient dignity, confidentiality, autonomy, presence, altruism, and those qualities which lead to trust-competence, integrity, honesty, morality, and ethical conduct.

This paper is based on a literature review to explore the current state of our knowledge about teaching and evaluating professionalism at the postgraduate level, highlighting areas of strength and gaps in our understanding. There are few references to professionalism specific to postgraduate medicine; therefore, much of the literature reviewed was about professionalism in general or at the undergraduate level.

There is some evidence that PGME programs, in their current form or the context in which they exist, fail to assist in the acquisition and subsequent development of the qualities that define professionalism, and, in some instances, may be detrimental to the development of the true professional (7). In the past, efforts to ensure that professionalism as an essential competency is learned at the postgraduate level appear to have been haphazard and dependent almost entirely upon role modeling. Professionalism must be addressed and taught explicitly throughout residency training in order that all trainees understand its nature, its importance to medicine's relationship with society, and the public expectations of them as professionals.

Based on the available literature, we have found the following key messages for the future of PGME:

1. The transformation of an individual from a member of the lay public to a skilled professional is a gradual process that occurs throughout all phases of medical education and results in the development of a new identity. Altering the learning environment so that it is publicly perceived as having a moral base, is dedicated to excellent patient care, supports the collegial nature of the medical profession, and does not tolerate unprofessional behavior must be an important objective in PGME.

2. Valid and reliable assessment of the professionalism of residents is necessary to reinforce the importance of professionalism. There is a need for the development of a variety of tools, including some form of valid and reliable global assessment, and of structured programs of remediation.

3. Faculty development is a powerful tool to get faculty buy in, to promote the understanding and vocabulary that is the basis of any program, to provide trained teachers and individuals to properly model professionalism, and to effect changes in postgraduate training programs. It is difficult to envisage major changes without a flourishing faculty development program.

Background

"Medical professionalism lies at the heart of being a good doctor". (1).

Current frameworks for postgraduate medical education list the core competencies essential to the practice of medicine (1,2,3). All contain and emphasize the role of the professional and the importance of professionalism. However it is defined, embedded in the meaning of the word professionalism are those characteristics which lie at the heart of the doctor-patient relationship and which traditionally have been associated with the role of the healer in society. They include caring and compassion, insight, openness, respect for patient dignity, confidentiality, autonomy, presence, altruism, and those qualities which lead to trust-competence, integrity, honesty, morality, and ethical conduct. (4,5 Appendix A) Many postgraduate trainees have these qualities before they enter medical school (6), and the role of postgraduate medical education is to recognize, cultivate and encourage them. In others, some or all may be lacking or under-developed (6) and the challenge is to assist in their acquisition and subsequent development. There is some evidence that postgraduate educational programs in their current form, or the context in which they occur, fail to do either and in some instances may be detrimental to the development of the true professional (7).

Postgraduate trainees need to understand the nature of professionalism, the reasons why society supports the privileged position of professionals, the history and evolution of professionalism, and the exact nature and reasons for the existence of their obligations as professionals.(4,5,8,9) From a pedagogical point of view the learning of these facts is relatively simple. The real challenge is to create an integrated and coherent teaching program that, as well as facilitating learning the cognitive base of professionalism, ensures that the core values of the professional become part of the persona of every practicing physician. (10) Only in this way can physicians meet their obligations to both patients and society under the social contract. This is also essential if physicians are to retain a sense of pride and purpose in their vocation. At the present time there is very little guidance in the literature to assist in establishing such a program at the postgraduate level.

It is also important to point out that there are no reports in the literature which document outcomes following specific interventions designed to promote the learning of professionalism at the post graduate level. The literature upon which this work is based consists largely of descriptions of the interventions themselves, opinions voiced by experts in the field, or original research on various aspects of the issue. Thus it is difficult to identify "best practices" which can meet the test of being evidence based.

This paper is one of 24 papers commissioned for the Future of Medical Education in Canada Postgraduate (FMEC PG) Project. The goal of the FMEC PG project is to assist medicine's educational mission in meeting its obligation to society to ensure that practitioners of the future understand and meet society's legitimate expectations.

Several important points deserve mention:

1. The transformation of an individual from a member of the lay public to a skilled professional is a complex social process that takes place throughout the continuum of medical education (11-14). The time spent in postgraduate formation is crucial to this process for several reasons. (15) First, the intensity of the experience becomes greater as a resident assumes increasing levels of responsibility. This has added impact as the resident has selected his or her discipline within medicine, and learning has more immediate influence and importance. In addition, the reality of practice in contemporary health care systems comes into conflict with those abstract ideals which have survived

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the medical student experience. Finally, closer contact with role models, both positive and negative, has an ever increasing effect on conscious and unconscious patterns of professional behavior.(16) It is clear that many aspects of training can have a negative impact on professional development. (17)It is therefore essential to address the issue of professionalism explicitly in all postgraduate training programs in order to make the experience as positive as possible.

2. The general principles governing the establishment of programs on the teaching, learning (14,18-20), and assessment (21-26) of professionalism at the undergraduate level have been developed and articulated. Grounded in educational theory, they can offer guidance at the postgraduate level.

3. At the undergraduate level, educational institutions can exert greater control over the balance between formal instruction and experiential learning. Thus it has been easier to establish integrated programs of instruction and learning. At the postgraduate level, this control is much diminished due to the necessary emphasis on service (27, 28), which is the basis of most experiential learning. For this reason the emphasis must be less upon formal instruction and more on exemplary role modeling which, combined with reflection, embeds learning in actual practice. The promotion of a safe and supportive learning environment is also essential.

4. The linked processes of role modeling, experiential learning, socialization and identity formation, and professionalism appear to be essential parts of postgraduate medical education. (12,14, 29) In spite of its importance, this area is underdeveloped in the literature.

5. A persistent theme in the recent literature relates to the time available for reflection in postgraduate medical education. (27,28) The service needs of patients, the almost universal Canadian shortage of health care personnel, and restricted duty hours challenge the ability of programs to provide sufficient time for the reflection and contemplation that are essential to professional development.

Methodology

A preliminary list of research questions was developed by the commissioned paper leads and a search of journal articles and grey literature related to the questions was performed by a McGill information specialist. Forty-one were obtained and entered into an Excel database and merged with a pre-existing McGill reference list. This merged list of 1335 items was coded by commissioned paper leads and three team members by level of relevance to the research purpose (3=high, 2=medium, 1=low). Total scores across raters were calculated and entries sorted by total score. Those with high total scores were retained, those with low totals deleted, and the rest flagged for further discussion. Next, the 306 entries in this shortened list were sorted into groups according to the research questions they helped to answer. A count of articles for each research question was done, and gaps in coverage were identified. Another review of the literature was done to fill in these gaps. Throughout this process, the analysis tended to shift back and forth from deductive to inductive (30), which allowed new themes and issues to emerge. Based on these emergent themes, the research questions were revised by the entire team. The 103 articles in the final short list were summarized and the lists of entries by research question were finalized.

It is important to note that there are very few references to professionalism with the terms postgraduate or residency in the title. Much of the literature reviewed in this paper is about

professionalism in general or at the undergraduate level, from which lessons and implications for professionalism of the postgraduate level are drawn.

The first draft of the paper was written and distributed to commissioned paper leads and team members, and, following their approval, to the Scientific Advisory Committee. It was also sent to representatives of Alberta, Ontario, and Québec Colleges of Physicians and Surgeons for their input. The final draft incorporates suggestions from the Scientific Advisory Committee and the three Colleges.

Discussion and Results

The material is organized around the final research questions.

I: What does professionalism mean in the PGME context?

There are several satisfactory definitions of professionalism which have been published. A list drawn from both the medical and social sciences literature is available. (5: Appendix A, 31-41) Each institution responsible for teaching professionalism at any level should select one already published or develop its own, with the admonition that any new definition must be consistent with the extensive literature on the subject. Medicine does not define professionalism by itself-professional status is granted to the medical profession by society.(42)

The presence of a definition recognized throughout an academic community is of fundamental importance as it provides a shared understanding of professionalism and a common vocabulary that serves as the basis of teaching, learning, and evaluation. (9,19,20)

In addition to understanding the nature of medical professionalism, residents should understand that professionalism serves as the basis for medicine's relationship to society. There is wide support for the concept that this relationship is a social contract and that professionalism serves as the basis for the contract. (41-42) Imparting knowledge of the social contract at all levels is important as it provides a logical base for the presence of professional obligations. Residency education is where actual experience of professionalism is rapidly increasing and the link between these concepts and the lived experience can be built upon.

It has long been recognized that the nature of the social contract, and hence of professionalism, is not static. (42,45,46) The importance of this cannot be underestimated as there is a tendency to attempt to teach what has been called "nostalgic professionalism". (46) The professionalism of today no longer emphasizes autonomy and altruism as it did in previous generations.

It also varies between different cultures and countries. (8,47) Each country determines its relationship between individual physicians and its medical profession. While one would hope that the professionalism learned by residents in Canada would reflect Canadian traditions and values, a part of the program of instruction must recognize that residents from different cultures (many of whom will return to their native countries) may find them unfamiliar. In addition, patients from different cultures and different countries may have expectations which differ from those of native-born Canadians. These contextual issues must be recognized and dealt with sympathetically.

While definitions serve as the core of the cognitive base of professionalism they do not describe the professional as a person. Consequently it has been necessary to develop a list of the attributes of the physician as a professional (4,31,48) in order to establish norms against which the performance of physicians can be measured. The attributes constitute an essential part of what is taught as they lead directly to the enumeration of the behaviors expected of a

professional. Behaviors serve as an important part of what is evaluated, and therefore represent a portion of the body of knowledge which must be learned. (23,49)

The definition of medical professionalism in any teaching institution should be the same for medical students, postgraduate trainees, and practitioners. While different aspects may have more or less relevance for an individual depending upon their place in the medical hierarchy, the definition itself should be constant for each institution.

The definition used throughout an institution should apply to all medical disciplines. In today's complex and specialized world, the conditions of practice in different medical disciplines may vary. This may require emphasizing different aspects of professionalism or using different methods of encouraging learning in order to address specific challenges inherent in some medical disciplines. (50-53). However, discipline-specific definitions are not required (54) and the core content is similar across disciplines.

Professions are granted privileges in society, one of which is self or physician led regulation. This confers upon the profession the authority, and hence the obligation, to set and maintain standards and to discipline unprofessional, incompetent, or unethical conduct. (55) The information that is available indicates that residents are largely unaware of their personal role in the regulatory processes or of the structure and organization of regulation. (32). This is a largely neglected and important part of professionalism. One of the most frequent criticisms of the medical profession is that its regulatory processes are inconsistent and do not sufficiently protect the public. (45,46) For this reason, teaching the role of medicine's institutions, including regulatory and certifying bodies, requires explicit attention as does the individual responsibility of each physician in the regulatory processes.(32,39,55)

In Canada, the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada are the standard-setting institutions for postgraduate medical education. Their definitions, descriptions, components and key and enabling competencies for the professional role are similar and reflect the concepts described above. (2,57) Both emphasize the attributes, commitments and behaviors that reflect professionalism, the concept of self-regulation and the social contract. There are slight but important differences between CanMEDS and CanMEDS-FM in that the latter has an extra key competency, "demonstrates a commitment to reflective practice", which include enabling competencies that clearly can be learned best at the residency level (know limits, seek help, self-awareness, reflect on practice events). In addition, both CanMEDS and CanMEDS-FM include the concept of physician health and sustainable practice under the professional role.(2,57) This is addressed in commissioned paper 23: Resident Wellness and Work/Life Balance in Postgraduate Medical Education. Nonetheless, the concept of physicians 'taking care of themselves so they can better care for others' is implicit in this document and is particularly important in the PGME context where the learning environment has the potential to have a detrimental effect on resident wellness.

II: How is professionalism learned?

For generations, postgraduate training was essentially an apprenticeship (27), and the application of educational theory came later. It is important to recognize that postgraduate trainees are adult learners (58): the organization of programs should reflect this.

 While this paper is concerned with postgraduate education, it is difficult to conceive of a flourishing program designed to foster the teaching and learning of medical professionalism which is limited to the postgraduate level. There is only one learning environment, and it impacts all- students, residents, and faculty. Changing this environment almost always involves altering the institutional culture. (14,41,59) Obtaining the support of faculty and hospital

leadership is an essential step in creating conditions in which professional behavior can flourish and therefore be transmitted. Deans, Associate Deans, Department Chairs and program directors must be involved (16,60) and professionalism must be explicitly addressed in the formal, the informal, and the hidden curricula.(61,62) It is fundamental that the academic community be aware of the presence of the chosen cognitive base and of the institution's commitment to professionalism. A variety of means are available to accomplish this: formal teaching programs on professionalism (63), faculty development (64,65), ensuring that professionalism is regularly discussed at formal rounds and integrated into bedside teaching (63), retreats etc. Of these methods faculty development is one of the most powerful, because it not only transmits knowledge of professionalism, but can provide a cadre of knowledgeable teachers.

Finally, it is necessary to name an individual who will be responsible for ensuring that the competency of professionalism is taught, learnt, and assessed at the postgraduate level. Along with the administrative role, this individual should serve as the advocate for professionalism within the faculty. (20)

A: How can professionalism be taught explicitly?

1. Identify what has been termed the cognitive base (20): an institutionally agreed-upon definition of medical professionalism, a list of its attributes and the concept of the social contract. This cognitive base should be the same for undergraduate and postgraduate education and for all faculty members within the academic community. It should provide a common vocabulary for all to use when professional issues are being discussed. An objective is to overcome the well-documented fact that different individuals, often within the same institution, have different interpretations of the nature of professionalism, which clearly makes it difficult to teach (13,33-37)

2. Teach the cognitive base explicitly to each resident in the program. While there is little data for guidance, logic would dictate that this should occur early and often in each resident's experience (63) so that the cognitive base can be built upon with experiential learning.

3. Provide for exposure to the cognitive base linked to reflection throughout the resident's training. Relying on only one or two formal sessions during a resident's experience is not sufficient. The opportunity to apply and use the concepts learned in the residents' daily life will embed them in their actual practice.

B: How can experiential learning and reflection be fostered?

1. The development of a professional identity depends upon experiencing real-life or simulated situations that challenge an individual's concepts and understanding. This is called experiential learning and its impact and effectiveness are heavily dependent upon reflecting on the experience. However, the initiating event must be the experience itself. Clinical experience is the most powerful because of its authenticity and direct relevance. The rotations in post graduate medical education are designed to provide the widest possible variety of clinical and nonclinical experiences and issues of professionalism will arise frequently as the resident progresses through the program. However, some aspects will be encountered infrequently or not at all and it is therefore important for program directors to supplement direct clinical experience by providing simulated situations which, in sum, will ensure that all aspects of professionalism will be subject to the reflective process and, one hopes, incorporated into the day-to-day practice of the resident. There are many methods to supplement direct clinical experience: experience

in simulation centers; discussion of case vignettes; analysis of narratives, written journals, portfolios; retreats, discussion of videos or the literature; role-plays; and others. (63,64,66-68)

2. Reflection has been described as "those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to a new understanding and appreciation" (69), a process thought to be activated by an awareness of need. In addition to being a powerful learning tool, reflection in practice is regarded as an essential component of professional competence (70-72)), and therefore must be addressed in postgraduate training. Reflection is particularly relevant and useful at the postgraduate level as evidence shows that younger individuals (students and residents) are more prone to reflection than are older practitioners. (73)

   During the reflective process, professionalism be learned through questioning, investigating, evaluating, analyzing, theorizing, seeking feedback, and incorporating the ideas and viewpoints of team members- all of which contribute to reflection. (66) A significant barrier to ensuring that reflection takes place is the lack of time available in postgraduate education. (27,28,74) Scheduled time in a safe and nurturing environment is required. Because group discussions have been shown to enhance the process (73), provision must be made to ensure that they take place as well.

C: What part do role models play?

1. Role modeling at the postgraduate level has an enormous impact, some of which is negative (13,14,17,74,75). Fully one third of residents have indicated that their clinical teachers were poor role models. (75) Positive role models are "individuals admired for their ways of being and acting as professionals" (75) and it has been suggested that an absolute requirement for improving the teaching of professionalism is to increase the number of physicians who can serve as good role models. (76) The impact of role models on both the hidden and the informal curricula is a significant factor that determines whether these curricula support or inhibit the transmission of professional values. (16) An important objective in any reorganization of postgraduate programs must be to effect improvement in this area.

2. The characteristics of good and bad role models are well known.(16,17,74,77) Three broad areas have been identified as being important: clinical skills; personal characteristics; and teaching ability. Within each, both positive and negative behavioral characteristics can be found (16). Of great importance are: time spent in both clinical care and teaching, stressing the importance of the doctor-patient relationship, and teaching the psychosocial aspects of medicine. (74,75) Virtually all observers highlight the importance of having role models be more explicit about what they are demonstrating.

   The importance of context in determining whether a given act or behavior is professional or unprofessional is now widely understood.(78) This is especially important for residents, who frequently have difficulty in distinguishing between the two during their training. (13) This emphasizes the importance of reflection on issues faced and, as noted above, being explicit about the content of what is being discussed.

3. In spite of the lack of concrete evidence to support it, there is a widely held belief that the performance of role models can be improved by interventions aimed at both training the role models and altering the environment. (13,16,17,64,65,74) Faculty development programs have been developed to improve the teaching and evaluation of

professionalism and a major objective of these programs has been to provide role models capable of being explicit about teaching professionalism. (64,65) At the present time, faculty development appears to be the tool which addresses the issue of role modeling most directly.

Altering the environment will be covered under the section addressing the formal, informal, and hidden curricula.

4. Residents are in contact with medical students on a daily basis and serve as powerful role models who can influence both the behaviors and the career choices of students.(82,83) It is important to train residents as role models as a part of their structured educational program and perhaps with targeted professional development initiatives. (64,65)

5. Regular performance assessment of role models is necessary to recognize and / or reward outstanding performance, remediate those who underperform, or remove persistent poor performers from the learning environment. A recent systematic review of questionnaires used for assessing clinical teachers (79) suggested that information should be derived from multiple and diverse sources, including self-assessment, to allow for triangulation of assessments. At the present time few studies attempt to directly assess the professionalism of clinical teachers including residents.(80) The use of computer-based programs that are capable of supporting the large-scale assessment of the performance of role models is just over the horizon (81) and has the potential to provide a foundation for evidence-based interventions to improve role modeling.

III: How is professional identity fostered in PGME?

1. Once more, there is a dearth of studies to support opinions in this fundamental aspect of postgraduate medical education. Nevertheless, the literature frequently suggests that there are those whose inherent qualities are such that they are more capable of performing like professionals (84). The process for selecting residents has come under scrutiny and new methods, such as the Multiple Mini- Interview (MMI) (85,86) have been proposed. (87) A more valid and reliable method of selecting residents who have an inherent ability to act professionally should be encouraged.

2. "The fundamental uncertainties that underscore clinical decision making, and the ambiguities that permeate medical practice, require a professional presence that is grounded in "who one is rather than what one does." (12) Identity formation is associated with attempting to influence who one is (14,29) and the process is usually referred to as socialization. Hafferty's summary of socialization and socialization theory can offer guidance in designing programs which can specifically influence the process.

   a. Socialization is aimed at training for self image and identity and involves a personal transformation in which one both becomes a professional and comes to regard one's self as a professional.

   b. Socialization takes place primarily at the tacit level and is more effective when it unfolds in a subtle and incremental fashion.

   c. Medical education is the site where professional culture is transmitted. This occurs during organized ceremonies and rituals but, even more powerfully, in the routine day-to-day events in the life of a resident. A nurturing environment can strongly influence the process of socialization.

d. Specific to medical professionalism, it is important to note that medicine is a moral community and residency programs are sites of moral acculturation.

e. The process of socialization in medicine reinforces the concept of professionalism as a force of social control at two levels: the level of self involving the capacity and willingness to regulate one's own self in the public interest; the collective level, involving a promise by medicine to police itself through self regulation. This should be made explicit during residency training.

f. Socialization in medicine is re-socialization of adult learners whose prior self is changed. This can cause difficulties as young adults must cope with the tensions which arise from changing their identity. They may use a variety of mechanisms, including adoption, compartmentalization, or rebelling which may explain some lapses in professional behavior seen in residents.

3. The concept that much of the process of socialization involves tacit learning leads directly to a consideration of the link between socialization, the learning environment, and the formal, informal and hidden curricula. (61,62) Approaching the curriculum in this way allows the design of actions aimed at influencing each component. The formal curriculum can promote the explicit teaching of professionalism and the process of socialization by recognizing the importance of both in mission statements and the objectives of the postgraduate program (41). The importance of professionalism is facilitated by the act of making time and resources available to promote reflection on the subject and by making what was hidden explicit. The informal curriculum is widely recognized as being almost indistinguishable from the culture of an institution and being closely linked with role modeling. Unfortunately, it often appears to have a negative effect. In some educational institutions activities aimed at altering the culture have been instituted and positive changes appear to have resulted.(41,58,88) Improving the performance of role models has also been recommended.(32,65). Closely related are activities aimed at altering the hidden curriculum. Making policies regarding reflection and socialization explicit are important. Giving proper recognition and financial support to teaching at the postgraduate level, assisting clinical faculty in understanding the process of socialization through faculty development, removing incompetent or unprofessional teachers, and providing sufficient time for reflection during postgraduate training are all examples of methods available.

IV: How can professionalism be measured/evaluated at the PGME level?

1. Recent landmark works have summarized the current state of our knowledge in this important field. (8,21-25,89,90). While there is agreement that current tools are inadequate, progress has been made and a vision of the design of a contemporary assessment program including the required individual assessment tools is emerging.

2. The article by Ginsburg et al (78) warned that professional behaviors are highly context dependent, and therefore any systematic method of assessing these behaviors must take into account the context in which they take place. Challenges to professional behavior often occur in situations where there is a conflict of values, and understanding how the conflict was resolved is necessary before a behavior can be properly assessed. Finally, students, residents and faculty have been shown to disagree on the interpretation of behaviors which could be labeled professional or unprofessional (13,91), indicating the need for caution. In this context, it must be remembered that residents have two roles that may influence their behavior: they are students responsible to faculty, and they are role models to those more junior. Because of the importance of

context, it has been suggested that the term "lapse in professional behavior" should be used rather than labeling a behavior "unprofessional".(49,91)

3. It is difficult to assess beliefs, values, or attitudes in a valid and reliable way and they do not always predict good behavior. Nor does behavior necessarily consistently or accurately reflect an underlying value or attitude. However the past decade has been marked by attempts to develop methods based upon observable behaviors which reflect these beliefs, values, or attitudes and which can be objectively measured. (23) Within the field of professionalism, the widely used Mini-CEX measures professionalism as a single category (92): this is insufficient. The Mini-CEX was used as a template for the development of the P-MEX to evaluate a series of behaviors that define the construct of professionalism. This tool was found to be valid, reliable, and reproducible in a pilot study (93), results which were subsequently confirmed in another culture. (94) Other validated quantitative tools have not yet appeared in the literature, but without question they will.

4. The deliberations of the Ottawa Conference Working Group (8) represent a recent effort which produced a nuanced set of recommendations about the assessment of professionalism. This group suggests that the overall assessment program and its component parts are more important than any individual tools. Multiple observations/measurements by multiple observers increase the accuracy of the assessments. While summative assessment represents a societal responsibility (95), formative assessment with feedback is of extreme importance for proper professional development. Finally, although most attention has been given to valid and reliable tools for assessing behaviors, there is a feeling that something is missed by focusing only on this approach (8,75,90,96) and that the development of some form of comprehensive and feasible global assessment plan by trained observers should emerge in the future.

The pioneering studies of Papadakis and her colleagues indicate that unprofessional behavior in residency may be associated with subsequent unprofessional activities in practice, (97), thus making it important to either offer remediation to individuals who demonstrate this behavior or remove them from the practice of medicine.

Rater training is important in ensuring the validity of the process.(89) Authenticity is of great importance and the issue of assessment and response to incidents of unprofessional behavior outside of the institution requires well-established and well-publicized policies. There is general agreement that frequent assessments throughout the educational experience are required. Summative assessments should be longitudinal at regular predetermined intervals. Summative evaluations are required at transition or decision points or where certain milestones are expected to be attained. There is an overlap between summative and formative assessments, with an accumulation of formative assessments being utilized for summative purposes, and summative assessments often assisting the formative.

V: What is the role of remediation?

It is surprising that, given the intense interest in the identification of unprofessional behavior or professional lapses, there is a paucity of work indicating what actions should be taken to both reward outstanding professional conduct, address professional lapses and identify those who are consistently behaving in unprofessional ways. Hickson and his colleagues (98) have offered a structure for approaching professional lapses or unprofessional behavior which is linked to feedback including remediation. The system was developed to respond to patient's complaints about both physician and resident behaviors. They correctly point out that the vast majority of

physicians are actually models of professionalism and require only reinforcement. Proceeding on an ascending scale of seriousness, there are single unprofessional lapses best treated by informal interventions. If an apparent pattern develops, what they term "awareness intervention" is required in which the information is shared with the individual in hopes that he or she will respond in a positive fashion. If the pattern persists, "authority intervention" is required in which leaders develop plans for remediation. If there is no change in behavior, disciplinary action must be taken.

Sullivan & Arnold (90) have provided a comprehensive approach to remediation. The essential steps are: define the nature of the professional lapse; investigate and characterize the lapse; set out a detailed plan for remediation, including the techniques to be used with the goal being behavioral change; establish a timeframe with goals to be met; and finally, follow the principles of due process and natural justice. The authors believe that success can be improved if the resident has insight, awareness and a willingness to change. Negative predictors include denial of the existence of the problem and a weak follow-up plan.

VI: How do generational issues impact postgraduate medical education?

Differences exist in the interpretation of the meaning of professionalism between generations. It has been pointed out that in the absence of such differences, human progress would be difficult. (99) Furthermore, as it is accepted that professionalism is constantly evolving, so must its definition. (46) Finally, the identities of those entering medicine are formed in a society which differs from those who have been in the profession for many years and they therefore have different hopes, aspirations, and expectations. (100) Generational differences have been described as a "useful proxy for the socio-cultural environment at different time periods". (101)

The differences that have been documented relate to relationships with authority, career expectations, learning styles, and approach to work-life balance. (99,101) Once again, the literature records differences and the controversies that arise from them, and suggests ways in which educational programs might be modified to better ensure that learning takes place. However, there are no outcome measurements that can assist in establishing "best practices". Finally, the differences should not be over emphasized. There are strong commonalities across all cohorts within medicine relating to fundamental core values such as honesty, integrity, trustworthiness, respect for patient confidentiality, and a commitment to serve. Those currently entering medicine appear to do so for the same reasons as did previous generations and selection committees for medical school and residency programs cross generational lines. (99)

To understand the implications for post graduate medical education it is not necessary to analyze in detail all of the societal differences responsible for the so-called generation gap or all of the differences themselves. However, it is helpful to be conscious of areas where the conflicts are important to professionalism, and where preferred learning styles require modification of teaching techniques.

The most significant tension between the beliefs of older physicians and the current generation relates to the conflict between altruism-a sense of obligation to put patient's needs above one's own- and the desire of residents to lead a balanced lifestyle which leaves time for family, friends, and outside interests. (102) This approach is given support by research which has shown that the judgment and performance of a tired or overstressed physician or resident can be impaired. An important result of this research has been limits on the hours which residents can work. The literature offers little guidance in how this essentially moral dilemma can be resolved, concentrating instead on time constraints. Duty hour restrictions and the role of resident associations that are perceived to be working in a resident's best interest cause conflicts for residents when they are trying to sort out what is in the patient's best interest. We

do not fully understand as yet all of the challenges to residents' professionalism by duty hour restrictions. If the medical profession is to retain the perception that physicians are altruistic, structures which can satisfy patients' needs for the "presence" of their physician while allowing for an acceptable lifestyle are required.   As this is an issue which now represents reality, training in the transfer of patient care should be expanded beyond "end of shift procedures" to include measures which are appropriate in practice. These include procedures for the appropriate transfer of responsibility and information, and means of ensuring that patients understand who is responsible for their care. This is clearly essential, but it appears that in parallel there must be structured reflection with two objectives: establishing the fact that altruism remains a professional characteristic essential for trust in both individual physicians and the profession; engaging residents in developing means whereby altruism can actually be operationalized in a modern context which protects their lifestyle in hopes that the patterns of personal choices will persist throughout their careers.

Summary

There is a consensus that medicine's professionalism is under threat and that postgraduate training programs of the future must address the issue to meet their responsibilities to both society and to the profession. In examining the literature and research questions, there are four broad themes that emerge and that serve as guides to efforts to ensure that Canadian residents emerge from their training programs as true professionals.

Addressing all aspects of professionalism explicitly

In the past, efforts to ensure that professionalism as an essential competency is learned at the postgraduate level appear to have been haphazard and dependent almost entirely upon role modeling. Professionalism must be addressed explicitly throughout residency training. Programs must specifically ensure that: there is an institutionally accepted definition of professionalism; the cognitive base is taught; opportunities for experiential learning of all aspects of professionalism are available in either real or simulated situations; time for structured reflection on these experiences in a safe environment is present; formative feedback is given; role modeling receives attention including faculty development; and generational issues are identified and addressed.

Assessment and remediation

Valid and reliable formative assessment of the professionalism of residents is necessary for two reasons. It emphasizes the importance of the subject and is the basis of formative feedback. Summative assessment fulfills an obligation to society in order to ensure that individuals exiting their postgraduate training program demonstrate professional behaviors.

At the present time assessment concentrates on professional behaviors, a process that must take into account the context in which the behaviors take place.

The results of assessing professional behavior must have consequences. Exemplary behavior must be rewarded, and structured programs of remediation must be available in order to deal with serious lapses or consistent unprofessional behavior.

There is a need for the development of a variety of tools, including some form of valid and reliable global assessment, and of structured programs of remediation.

Identity formation and socialization

The transformation of an individual from a member of the lay public to a skilled professional is a gradual process that occurs throughout all phases of medical education and results in the development of a new identity. While the literature in medicine directly addressing this subject, particularly at the postgraduate level, is not extensive, it is sufficient to highlight the importance of the two related issues of the learning environment and role modeling. Altering the learning environment so that it is publicly perceived as having a moral base, is dedicated to excellent patient care, supports the collegial nature of the medical profession, and does not tolerate unprofessional behavior must be an important objective in post graduate medical education. For this to occur, role modeling, which is so essential to the creation of a professional identity, must be addressed specifically. Positive role models must be identified and rewarded and those whose behavior or actions are detrimental to the formation of a professional identity must be offered remediation or removed from contact with residents.

Faculty development

Faculty development will be addressed by another FMEC PG team (see discussion paper 21: Faculty Development for PGME – The Road Ahead) but it is so important for learning professionalism at the postgraduate level that it is included as a major theme. Faculty development is a powerful tool to get faculty "buy in", to promote the understanding and vocabulary which is the basis of any program, to provide trained teachers and individuals to properly model professionalism, and to effect changes in postgraduate training programs. It is difficult to envisage major changes without a flourishing faculty development program.

"Teaching professionalism is not so much a particular segment of the medical curriculum as a defining dimension of medical education as a whole." (103)

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Appendix 1: About the Authors

Dr. Richard L. Cruess graduated with a Bachelor of Arts from Princeton in 1951 and an MD from Columbia University in 1955. He is Professor of Orthopedic Surgery and a Member of the Centre for Medical Education at McGill University. An orthopedic surgeon, he served as Chair of Orthopedics (1976-1981), directing a basic science laboratory and publishing extensively in the field. He was Dean of the Faculty of Medicine at McGill University from 1981 to 1995. He was President of the Canadian Orthopedic Association (1977-1978), the American Orthopedic Research Society (1975-1976), and the Association of Canadian Medical Colleges (1992-1994). He is an Officer of The Order of Canada and of *L'Ordre National du Québec*. McGill University has established the Richard and Sylvia Cruess Chair in Medical Education. Since 1995, with his wife Dr. Sylvia Cruess, he has taught and carried out independent research on professionalism in medicine. They have published widely on the subject and been invited speakers at universities, hospitals, and professional organizations throughout the world.

Dr. Sylvia R. Cruess graduated from Vassar College with a Bachelor of Arts in 1951 and an MD from Columbia University in 1955. She is an Endocrinologist, Professor of Medicine, and a Member of the Centre for Medical Education at McGill University. She previously served as Director of the Metabolic Day Centre (1968-1978) and as Medical Director of the Royal Victoria Hospital (1978-1995) in Montreal. She was a Member of the Deschamps Commission on Conduct of Research on Humans in Establishments. Since 1995, with her husband Dr. Richard Cruess, she has taught and carried out research on professionalism in medicine. They have published extensively on the subject and been invited speakers at universities, hospitals, and professional organizations throughout the world. She is an Officer of the Order of Canada, and McGill University has established the Richard and Sylvia Cruess Chair in Medical Education.

Dr. Linda Snell is a Professor of Medicine and an active member of McGill's Centre for Medical Education. She completed her undergraduate and medical education at the University of Alberta, her residency at McGill University, and has a Master's degree in Medical Education from the University of Illinois at Chicago. She is currently Vice-Chair (Education) of the McGill Department of Medicine, Director of McGill's Postgraduate Core Competency Program and has recently been appointed Senior Clinician Educator for CanMEDS at the Royal College of Physicians and Surgeons of Canada. Linda has been active in teaching, administration and educational research at all levels of medical training. Her current interests include improving teaching skills of faculty and residents, issues in clinical teaching and learning, teaching & evaluating CanMEDS core competencies (including the Professional Role), leadership in medicine and medical education and educational scholarship. She has led and participated in various faculty development and teaching improvement programs across Canada and internationally, including the Royal College Professional Role Train-the-Trainer' program. She has a busy general internal medicine practice.

Dr. Shiphra Ginsburg is an Associate Professor, Department of Medicine (Respirology), and an Adjunct Scientist, Wilson Centre for Research in Education, both at the University of Toronto. She is also the Director of Education Scholarship and the Director of the Clinician-Educator Training Program for the Department of Medicine, and the co-Director of the Centre for Faculty Development's new certificate course "CoFER" (Core Foundations in Education Research). Her research program has focused on professionalism, the evaluation of clinical competence, professional identity formation, education scholarship, and qualitative methodology. Dr. Ginsburg participates in professionalism initiatives at the local, national and international levels, and serves as Deputy Editor at the journal Medical Education, and as a Fellow on the Editorial Board of Academic Medicine. She is the current Kimball Scholar at the American Board of Internal Medicine. Dr. Ginsburg enjoys mentoring other faculty members in the development of their own research and scholarship.

Dr. Ramona Kearney is professor and associate dean of postgraduate education in the Faculty of Medicine and Dentistry at the University of Alberta. She is a pediatric anesthesiologist and former residency program director of anesthesiology. She served as committee chair in Anesthesiology for the Royal College of Physicians and Surgeons of Canada and is now a member of their evaluation committee. She obtained a master's degree in medical education from the University of Dundee in 2003 with thesis work in professionalism.

Dr. Valerie Ruhe has a Phd in Education (Measurement, Evaluation and Quantitative Research Methodology) from UBC. She is an Assistant Professor at McGill's Centre for Medical Education, where she evaluates the Physicianship program, provides consulting services on assessment and teaches a course on program evaluation. She designed a validation study of McGill's medical residents ITER scores. With Dr. Bruno D. Zumbo, she co-authored *Evaluation in distance education and e-learning: The unfolding model.*

Dr. Simon Ducharme is a fourth year psychiatry resident at McGill University and is completing a research MSc. He has obtained his medical degree from the Université de Montréal in 2007, receiving the Sir William Hingston medal for the highest academic standing. He has published on pharmacotherapy and neuropsychiatry. He collaborates with the NIH Normal Brain Development Study and his project on neuroimaging of behavioural traits in healthy children was funded by CIHR and the McGill Department of Psychiatry. He is on the board of directors of the Association of Residents of McGill (ARM) and the Douglas Mental Health University Institute. His career interests are neuropsychiatry and psychiatric neuromodulation. He has received the 2011 Young Investigator Award from the American Neuropsychiatric Association and plans to do a fellowship in neuropsychiatry/ behavioural neurology.

Dr. Robert Sternszus is a second year Pediatric resident at the Montreal Children's Hospital. He completed his undergraduate training at McGill University. He is involved in research with McGill's Centre for Medical Education, aimed at evaluating the impact of resident role models on undergraduate students. He is also involved in the teaching of professionalism and communication at the undergraduate level.

Appendix 2: Annotated Bibliography

Cruess RL, Cruess SR, Steinert Y, editors. Teaching medical professionalism. Cambridge, UK. Cambridge Univ Press. 2009. 310 p.

This recent text summarizes current knowledge of teaching and assessing professionalism at all levels. It contains chapters on: the cognitive base of professionalism; principles for establishing teaching programs on professionalism; educational theory and strategies; links between professionalism and socialization; assessment of professionalism and remediation for unprofessional behavior; the role of regulatory bodies in medical education; faculty development for professionalism; and gender issues. The appendix lists definitions of professionalism from two dictionaries, four social science sources, four medical literature sources and from Canadian, British and American medical organizations. It also contains two chapters on teaching professionalism at the postgraduate level.

Ginsburg S, Regehr R, Hatala R, McNaughton N, Frohna A, Hodges B, Lingard L, Stern D. Context conflict and resolution: A new conceptual framework for evaluating professionalism. Acad Med 2000;75 (10 Suppl):S6-811.

The authors present a new conceptual framework of evaluation based on behaviors in context. Value conflicts need to be considered when evaluations are designed. Methods of evaluation should include elements of peer assessment, self-assessment and longitudinal observation. The need to understand why students demonstrate occasional lapses in professional behavior to develop effective teaching and remediation is stressed.

Hilton SR, Slotnick HB. Proto-professionalism: How professionalisation occurs across the continuum of medical education. Med Educ 2005;39(1):9-11.

The authors consider the nature of professionalism and how it emerges and relates to the work carried out by doctors and doctors-in-training. They suggest six characteristics: ethical practice; reflection/self-awareness; responsibility for actions; respect for patients; teamwork, and social responsibility. A defining characteristic is "phronesis", or practical wisdom, acquired only after a prolonged period of experience, reflection, and an evolving knowledge and skills base. Influences on proto-professionalism, the prior period, involve moral and psychosocial development and reflective judgment. Curricula that develop meta-skills will foster the acquisition and maintenance of professionalism. Adverse environmental conditions in the hidden curriculum may have powerful attritional effects.

Professionalism Theme Working Group. Post-conference draft Recommendations International Ottawa Conference.[Internet]. Miami, 2010. [Cited 2011 Feb 4] Available from:
http://www.ottawaconference.org/images/stories/Assessment_of_Professionalism_1.pdf

The authors provide very insightful recommendations for the assessment of professionalism. There are eight general principles for assessing professionalism, involving the cultural context, dialogue between professionals and the public, summative/formative and cultural and societal relevance. The defining traits of professionalism can be grouped into: individual level, interpersonal level, and institutional/system/societal level. The authors make recommendations for each group. Finally, there are 10 recommendations for future directions for research.

Wilkinson TJ, Wade WB, Knock LD. A blueprint to assess professionalism: Results of a systematic review. Acad Med 2009;84(5):551-558.

The authors reviewed assessment tools, clustered the definitions of professionalism, created a "blueprint" and matched the elements of professionalism to relevant assessment tools. Professionalism is a multidimensional construct with five clusters: adherence to ethical practice principles, effective interactions with patients and with people who are important to patients, effective interactions with people working within the health system, reliability, and commitment to autonomous maintenance / improvement of competence in oneself, others, and systems. Professionalism can be assessed using a combination of observed clinical encounters, multisource feedback, patients' opinions, paper-based tests or simulations, measures of research and/or teaching activities, and scrutiny of self-assessments compared with assessments by others.