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FUNDAMENTALS OF GOOD MEDICAL PRACTICE: TEACHING AND ASSESSING PROFESSIONALISM

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In my first article of the series "Fundamentals of Good Medical Practice: The Basis of Professionalism" published in the March 2012 issue of the Basrah Journal of Surgery[1] I discussed the definition and framework's foundation of professionalism, which in few words they consists of: clinical competence, good communication skills, and a sound understanding of the ethical and legal aspects of medicine. The latter part includes: accountability, altruism (putting the interests of patients and society consistently ahead of one's interest), excellence and humanism. In this part I will discuss the "Teaching and Assessment of Professionalism".

A frequent question is asked by any one of us as medical doctors and widely in the community is: 'Am I, or is he / she a good medical doctor, and how does one become a good medical doctor?'

The traditional, basic, formal medical training constitute of 'Mastering Knowledge' and 'Acquisition of Technical Skill'. Therefore if a medical doctor is able to grasp these two elements then it is assumed that the doctor is 'good'. Although these two essential elements are necessary, however, they are not sufficient to grant that status[2,3]. Combining these with professionalism is what truly defines the 'good medical doctor'[4].

The central task of clinical education is how to prepare doctors in training to eventually become independent in their decisions and dedicated to the well-being of their patients. Traditionally this is conducted through an apprenticeship pattern in which more experienced doctors pass on essential knowledge and skill to their junior colleagues and continue to help them with regular mentoring.

There is some thought that ethical teaching despite its importance have been somehow deficient in the medical school and residency curricula because there are many other sciences and scopes, which must be taught and learned leaving less and limited time for teaching professional attitude[5]. In recent years there has been a growing sense that giving more attention to formal ethics curricula should enhance both the clinical and ethical aspects of decision making skills and professional values necessary to grant the status of a 'good medical doctor'[5]. However, there is some thought that it is still unclear as what is the best way to promote and evaluate professionalism[6].

Medical doctors in training report that the values exhibited by their teachers and institutions have a direct impact on their own professionalism[7]. Based on that experience there are other reports, which unfortunately suggest that there are a significant number of medical students and doctors who are dissatisfied with their formal training and teaching in professionalism because they are experiencing a culture of cynicism (i.e. the

belief that people always act selfishly) during that period[8]. I think this is an important point, which teachers should keep it in their mind rather than assuming that they are delivering 'good' education and forgetting the assessment and satisfaction of the learners.

On the same background mentioned earlier, Roberts et al[3] thought that learning, which handles practical ethical issues and developing one's professional identity as a medical doctor, are essential steps in becoming a good doctor. The authors also thought that the majority of ethics and professionalism teaching at the undergraduate and even postgraduate level is still broad and general. They were also aware that although different curricula have been developed they were still lacking in taking into consideration the views of those doctors-in-training about their needs for ethics instructions. For that reason the authors conducted a written survey to all medical students and 1st to 3rd year postgraduate residents (registrars) at the University Of New Mexico School Of Medicine. Out of those surveyed 65% of students and 58% of residents responded to the survey. From that study the authors affirmed the value of ethics preparation as seen by medical students and residents, and the need for greater curricula in ethics education directed at practical ethics and ethically important professional development topics during medical training. The authors also concluded that academic medicine may be better able to fulfil its responsibilities in teaching ethics and professionalism and in serving its trainees by paying greater attention to these topics in undergraduate and graduate medical curricula[3]. These facts also reflect the belief that professionalism is a characteristic that can't be instilled effectively without the direct participation of the learner[9].

Teaching Professionalism

Based on what has been briefly discussed above I think one can raise three questions: (1) is it possible to 'teach' professionalism? (2) If so can it be 'learned'? and (3) if it is able to be taught and learned, then is it feasible to 'assess it'?

I thought these are huge tasks and need well knowledge in the subject, passion about introducing a well-balanced frame to that subject and ability to satisfy the readers based on specific application of these ideas. During my search in the literature I came across several articles, which I thought after reading them in full they gave me good satisfaction and therefore decided to share them and discuss them with our readers. As you will see I made comments in appropriate places.

In these papers the three raised questions received a 'Yes' answer. If you are able to 'teach' a subject then you need to give good reasons why you want it to be taught. Then the ways you are able to pass the knowledge to other concerned parties, who in this setup are the medical students, the trainees, and practicing medical doctors. If this is achieved then the subject is able to be 'taught'. And finally in order to maintain the standard of the subject and improve it then it should be 'assessed'.

Mueller[10] gave some details on several aspects and ideas of this subject, which I am going to briefly present and supplement them with inputs from other reporters.

Reasons for teaching and assessing professionalism[10].

(1) Teaching and assessing professionalism does not occur by chance alone.

(2) Patients expect medical doctors to be professional.

(3) Medical professional societies expect professionalism to be taught and assessed.

(4) Professionalism is associated with improved medical outcomes.

(5) Unprofessional behaviour is associated with adverse medical outcomes.

(6) Accreditation organizations require that professionalism be taught and assessed.
(7) Professionalism can be taught and learned.
(8) Professionalism can be assessed.

Teaching and assessing professionalism does not occur by chance alone: In order for the concerned parties to become and remain professional then the elements of the framework of professionalism should be intentionally taught. In addition assessment motivates individuals to learn what is important and helps determine whether competency has been achieved[11].

Patients expect medical doctors to be professional: Bendapudi and colleagues[12] conducted a telephone interview focused on physician-patient relationship with 192 random patients who were seen at 14 different medical specialties of Mayo Clinic at Scottsdale, Arizona and Rochester, Minnesota in 2001 and 2002. Patients were asked to describe their best and worst experiences with a physician (medical doctor) and to give specifics of the encounter. Subsequently the interviewers independently generated and validated the following 'seven ideal behavioral themes' that emerged from the interview transcripts. The words between brackets are some of the patients own expressions. The ideal physician (medical doctor) is Confident (the doctor's assured manner engenders trust), Empathetic (tries to understands my feelings and what I am experiencing), Humane (caring, compassionate and kind), Personal (interested more in me than just being a patient), Forthright (tells me what I need to know in a plain language), Respectful (takes my input seriously and works with me), and Thorough (is conscientious and persistent). According to Li[13] the opposites of these behaviours are: Timid, Uncaring, Cold, Callous, Misleading, Disrespectful, and Hurried respectively. One wonders whether it is really possible to deliver a high-quality health care if the patient-medical doctor interactions have these, latter behaviours.

Pellegrino[14] suggests that predictable physician (medical doctor) behaviours flow from character 'traits' (characteristic feature) or 'virtues' (moral goodness). These virtues of the good medical doctor are: Benevolence (kind and helpful), Compassion, Courage, Fidelity to trust, Intellectual honesty, Prudence (cautious and sensible), and Truthfulness[14].

In another study[15] 'compassionate care' was the most predicted patient' willingness to return for or recommend the medical doctor to others in the 'outpatient setting', whereas 'delivery of care' and 'compassionate care' were the most predicted willingness to return for or recommend the medical doctor to others in the 'inpatient setting'.

Medical professional societies expect professionalism to be taught and assessed: In my previous publication[1] I presented how different medical societies including the "Physician Charter"[16] expect professionalism to be an important aspect of competency. Notably, within 15 months after the release of that chapter it was endorsed by 90 specialty societies[17]. These facts, affirms the importance of teaching and assessing professionalism.

Professionalism is associated with improved medical outcome: Keeping in our mind the basis of professionalism then it is easy to understand how it is going to improve the medical outcome. From the medical doctor side, adherence to professionalism is associated with overall excellence in knowledge, skills and conscientious behaviours[18]. And from the patient's side, one will expect increased patient satisfaction and trust, adherence to planned treatment and therefore feel comfortable staying with the same medical doctor, leading to fewer complaints and less litigation[18].

Unprofessional behaviour is associated with adverse medical outcomes: I think there are three facts related to this point. The first, related to the results of several

studies and surveys, which confirm the presence of different modes of unprofessional behaviour among some 25% to 30% of practicing medical doctors of different specialities[19,20]. These includes: disrespect, yelling, insults, abuse, and refusal to complete duties[19,20]. The second, is the belief that disruptive physician behaviour were linked to adverse events (e.g. medical errors)[21]. And the third, which is an interesting finding, is the evidence, which suggest that unprofessional behavior among practicing medical doctors can be predicted during medical school, e.g. poor reliability and responsibility, lack of self-improvement and adaptability, and poor initiative and motivation[22,23]. This type of link had been confirmed in a large study involving 40 U.S. state medical boards[24].

Accreditation organizations require that professionalism be taught and assessed: As I mentioned in my previous article[1] all accreditation and licensing organizations and all respectable institutions and societies have established their own rules and requirements, and recommends that institutions should teach, observe and assess professionalism. One example to that is "The Joint Commission", which is an independent, non-profit organization that accredits and certifies healthcare organizations in the United States, has issued standards that address unprofessional healthcare worker behavior[25]. Failure to meet these standards risks accreditation and certification.

Professionalism can be taught and learned: In order to achieve a successful teaching outcome then a qualified, dedicated, knowledge personal are required; and in order to reach a successful learning scheme then an interested, committed group of learners are required. In addition to these two parties and in order to regulate that process then there is a need for framework and feedback. Established curricula are the framework, and the feedback can be generated from the discussion between the two parties and other independent observers.

The curricula are described to be: 'formal', 'informal' and 'hidden'[26]. The 'formal curriculum' is the stated, intended and formally offered and endorsed curriculum[26]. The 'informal curriculum' is an unscripted and highly interpersonal form of teaching and learning that takes place among and between the teaching faculty and students[26]. And, the 'hidden curriculum' is a set of influences that function at the level of organisational structure and culture[26]. Teaching may be conducted through didactic and web-based learning module[10]. Other means of teaching include interactive teaching methods such as case discussion and hands-on practice sessions, which can improve both learner performance and patient outcomes[27]. Another way of teaching is the role-modelling in which learners observe and adopt the attitudes and behaviours of their role models[28]. The 'hidden curriculum', is the teaching and learning that occurs in clinic, hospital hallways, on call rooms and patients rooms and largely delivered by role models who have a powerful influence on learners[26,28].

Added to these there are a number of strategies, which should exist to enhance teaching professionalism. These includes: establishment of a culture of humanism, the curriculum should be practical and relevant to the field of study (for example surgery), engaged in communication skills, self-reflection should be encouraged like writing manuscripts for presentation and/or publications, assembling discussion groups and others, and finally, negative role-models and disruptive physician educators should be identified and dealt with them accordingly[10,29].

Professionalism can be assessed: I think there are four aspects (questions) related to this part. The first is the question whether professionalism is able to be assessed? If the answer is 'yes' then the

second question will be 'why?', the third question is 'how?', and the fourth aspect if it is able to be assessed then 'what are we going to do with that assessment?' Although some reporters feels that the best way to evaluate professionalism among medical doctors is unknown[9], on the other hand other reporters gave an evidence, which indicates that it can be assessed[30,31].

There are several reasons why professionalism must be assessed. Firstly, similar to any other clinical topic, assessment will determine if medical students, trainees and practicing medical doctors meet competency and whether they realize that the subject is important and valuable. Secondly, learners in general will try serious attempts of understanding and grasping the subject when they knew that at one stage they must undergo an assessment. Thirdly, an assessment will act as a feedback element to both parties involved and a mean of evaluating the curricula. And finally, it will identify the different types of learners as whether they are exemplars (models) and therefore reward them, or guide those with lapses, or dismiss those who can't achieve competency[10,28].

Although there is no universal tool for the assessment exists[30], it is suggested that the assessment should start early and continue through the whole process[30]. It should involve cognitive (acquiring knowledge), behavioral and effective outcome which, is relevant and within the expectations of the specialty setting of the learner (for example surgical registrar) and the learners' developmental level[10,28,30,31]. Multiple tools for assessment should be used to validate the assessment. These could include tests of knowledge and skills, review by faculties attending the teaching sessions, OSCE (Objective Structured Clinical Examination), patients' assessment to the medical doctor, patients' complaints, and incident reviews[10,28,30,31].

In response to the fourth aspect this assessment can be put together as part of the 'professionalism portfolio', it can be used as a 'feedback information', also as mentioned before it will identify the different groups of learners, and finally the gathered data can be used to enhance the programs and may be used for research on professionalism[10,28,30,31].

Mentors and Role Models

Above I used the words 'Mentor' and 'Role Model'. Because a specific aspect of teaching has been discussed then I am taking this opportunity to briefly clarify and discuss what is exactly meant by these terms.

'Mentoring' is a process whereby an experienced, highly regarded, empathetic person (the Mentor) guides another person, usually younger individual (the mentee) in the development and re-examination of their own ideas, learning, and personal and professional development[32]. The mentor is usually but not necessarily works in the same organisation or field as the mentee. A good and successful mentor should support and facilitate, listen, teach by example, encourage and motivate, promote independence and balance, and rejoice in the success of their mentees[33]. Conversely, threatening, taking credit, taking over, imposing influence, and assuming the role of problem solver are attitudes that can have negative impact on mentees[33,34]. Mentorship as was described by Singletary[34] is a process that can be learned and mentors should be given appropriate time and funding to develop their skills.

In today's current practice aspiring surgeons may require more than one mentor such as for conducting research and personal development besides clinical aspects. Such mentorship is called 'mosaic mentoring'[34,35]. Another form of mentoring is what is called 'collaborative or peer group mentoring' in which there is no gap between the mentor and mentee because

both of them have similar status and /or experience. This will provide an excellent addition to the traditional mentorship namely by enhancing professional development through collaborative work relationship[33,34]. Although the existence of 'mentoring program' seems to be logical, however, in the literature there is minimal prevalence about the presence of such programs whether formal or informal[34].

Paice et al[36] described Roles Models as "people we can identify with, who have qualities we would like to have and are in a positions we would like to reach". These people are spending considerable amount of time in teaching, highlighting the importance of doctor-patient relationship and also teaching the psychosocial aspect of medicine[37]. Besides these characteristics they also possess research capability, leadership, teamwork, professionalism, and commitment to excellence[34].

From the descriptions mentioned above one can notice the difference in the role played by the mentor and the role model. A role model may not necessarily play as a learner, yet his / her actions and attitudes may be consciously or unconsciously observed by juniors, which tend to drive them imitating their role model's approaches and practices[34].

On the other hand, although role modelling and mentorship are clearly, have different pathway roles it is imperative that good role models should also be good mentors[33,34].

Final comments

This part covered several, somehow challenging but important aspects about teaching and assessing professionalism. It identified what is meant by 'good medical doctor' and the 'ideal medical doctor'. It confirmed that professionalism is able to be taught, learned and assessed, and the reasons why to do so. We found how it is involved deeply in our clinical, practical daily work, and how it improves patients' management outcome and subsequently medical outcome in general. It showed us how unprofessional behaviors could be damaging and therefore should be identified and dealt with appropriately. The roots of these unprofessional behaviors could be traced to the attitude of the medical student during medical school. Lastly, in order to have a successful teaching program it should be well supported by dedicated groups, both teachers and learners, and regulated by practical, relevant curricula.

With this second part about professionalism it complemented the first part of the topic[1] and by doing so I will present and discuss another aspect of 'Fundamentals of Good Medical Practice' in the next issue.

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