Professionalism in Residency Training

By A/Prof Nicholas Chew

IN 2012, renowned UK educationist and writer, Sir Michael Barber, led an essay entitled "Oceans of innovation" in which he summarised what a well-educated child should learn in the following neat equation:[1]

Well-educated = E(K+T+L)

Where
K is knowledge as described by "know what" and "know how";
T is the ability to think, reflect and improve;
L represents leadership in the sense of having the ability to influence people.

Ethics (E) took a special mathematical position in this formula. The multiplier effect meant that without ethics, the writers opined that the child would not be considered well educated at all and perhaps, arguably, a potential menace to society.

In extending Barber's future-oriented concept to graduate medical education, it is clear that ethics and professionalism would hold a similar "mathematical position". The fact that doctors need to be professional, in addition to being ethical, stems from our beginning as a guild and the social contract that we created with society. This social contract allows doctors the privilege of autonomous profession-led regulation in return for adherence to certain behaviours. Cruess et al described these behaviours as the guarantee of competence, provision of altruistic service and upholding of morality and integrity.[2] While written in different terms, the centrality of these ideas can be seen in competency frameworks such as the CanMEDS roles[3,4] and Accreditation Council for Graduate Medical Education (ACGME) core competencies.[5]

Assessing competency in professionalism

Since the 2010 nationwide adoption of competency-based residency education, similar competencies have been used in all Singaporean residency programmes to train specialists. All residents now attend mandatory courses in ethical practice and professional regulation as guided by the Singapore Medical Council's Ethical Code and Ethical Guidelines,[6] and are regularly assessed on their professionalism.

While no doctor would dispute the importance of professionalism, we constantly struggle with *how* to determine if individual residents are "competent in professionalism". Competency committees across Singapore have debated and struggled to contextualise these ideas. Assessment forms have been created, destroyed, recreated and re-destroyed in what seems like endless cycles of iterative improvement in search of a perfect assessment system that does not exist.

Most programmes eventually settle on a pragmatic two-stage system of assessment that involves: a) the aggregation of episodic data derived from a small sample of people, at time intervals far apart enough so as to maximise the sanity of faculty and supervisors; and b) awaiting any reports or complaints of "unprofessional conduct" about the residents that might reach the competency committees.

These systems are not unique to us, as they are, for most parts, similar to residency programmes globally.

Rethinking "professionalism"

How useful is this, really? Let me present two thoughts on why we might need to reconceptualise professionalism as a competency.

Healthcare is increasingly being described as a "team" or "contact" sport rather than a "solo" sport. Today, it is hard for us to conceive of an individual doctor who is capable of independently delivering all aspects of care. The need to work in healthcare teams and healthcare networks fundamentally challenges the concept of professionalism being an individual competency. Is it possible for individuals to be a role model of professionalism and yet, as a team, become unprofessional?

Consider the following requirement in the ACGME professionalism competency to demonstrate "accountability to patient, society and profession".[5] As an individual, a resident can be accountable for his actions and take effort to ensure high–quality work. His supervisors will assess him favourably, nurses will rate him highly and the competency committees will rightly opine that he is competent. Yet in complex systems such as medical teams, healthcare is replete with stories of how the best intentions and efforts of individuals are simply insufficient in preventing errors from occurring – errors that could potentially harm patients, even though the individual doctor might be competent in demonstrating "accountability to patient".

Individual competence in professionalism is insufficient to ensure that the team, as a whole, manages the patient with professionalism. Lorelei Lingard has researched team work and collective competence extensively. In *The Question of Competence*, she wrote that collective competence is achieved through a process of participation rather than acquisition.[7] We need to start exploring how to teach professionalism in inter-professional teams that learn and work together. However, our current training systems are not prepared for the changes needed. There are few examples of healthcare services being delivered in such "clinical microsystems", where team members are able to consistently work, train and improve together.

My second thought revolves around the context in which assessments of professionalism take place. Within the confines of residency supervision, caseloads, duty hour requirements and systems of practice, a resident who consistently demonstrates professionalism within this scope of practice is rightly thought of as being competent. But what happens if the system changes? What if the entire context of practice evolves, as it undoubtedly will, in the next five years, and the doctor would then have to practise in environments he had never trained for?

The challenge is real. The advent of the Regional Health Systems (RHS) requires fundamental changes in the way healthcare delivery is structured. Doctors will become increasingly involved in population health and discover how the social contract that we share with society changes with our new roles in the RHS. How then do professionalism competencies change? Would a resident trained in today's system still be competent for future practice in the RHS?

Challenges ahead

Consider another ACGME requirement for professionalism: "sensitivity and responsiveness to a diverse patient population".[5] In the context of a hospital/tertiary care centric model, we can understand how a resident might demonstrate his responsiveness to the needs of patients from different segments of society. However, the same competency becomes far more challenging from a population health perspective. Firstly, the idea of the "patient population" will need to expand into unfamiliar territories "upstream" and "downstream"; that is, the population spanning those who are well in community to those who are in the intermediate, long-term and, possibly, palliative care. Secondly, the needs of this population change dramatically. Much more emphasis will then need to be placed on the interfaces between medical and social services, working with non-healthcare partners in the community and teaching patients and family to care for themselves and each other.

Graduates from the current training systems will be challenged with a need to appreciate the changes in the practice environment, analyse the new relationship between doctors and society, and respond appropriately. Only then can they continue to demonstrate "sensitivity and responsiveness to a diverse patient population".

Professionalism is a living concept that will continue to evolve as healthcare delivery systems change. The challenge is upon us, as current stalwarts in healthcare, to shape the way we evolve professionalism for our collective futures. ■

References

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A/Prof Nicholas Chew is a senior consultant psychiatrist in the Department of Psychological Medicine in Tan Tock Seng Hospital. He completed the Masters of Science in Health Professions Education at the Massachusetts General Hospital Institute of Health Professions in 2013 and currently serves as the group chief education officer for the National Healthcare Group and the designated institutional official for National Healthcare Group Residency.