

## 5. Professionalism

### A White Paper Prepared for the Royal College of Physicians and Surgeons of Canada, Future of Medical Education in Canada

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#### Summary of Key Points

- Medical professionalism is fundamental to all aspects of the teaching and practice of medicine
- Medical professionalism is an individual competency formed and informed by institutional, systemic and societal cultures that can nurture or impede its development and expression, and thus the cultural context must be acknowledged and understood
- The challenges and drivers for change include:
  - Societal expectation
  - Collaborative care models
  - Rising malpractice complaint rates
  - High rates of medical error
  - Rates of physician impairment and mental health issues
  - Advances in technology and medical science
  - E-professionalism
  - Negative perceptions of professionalism amongst trainees
  - Threat to self-regulation
  - Conflict of interest policies

#### Summary of Recommendations

1. Professionalism must remain a central element of post-graduate medical education.
  - a. *Accreditation*
    - i. The Royal College accreditation standards must maintain the mandate of teaching and assessment of medical professionalism as core components in all phases of residency-training programs.
    - ii. The Royal College Office of Education should take an active role in disseminating appropriate, effective teaching resources on professionalism for residency training programs.

- iii. The Royal College should take a lead in collaborating with other credentialing bodies in order to foster development or identification and implementation of educationally sound teaching methods and rigorous assessment methods for medical professionalism across the continuum of medical education from undergraduate to physicians in practice.
- b. *Teaching of Medical Professionalism*
  - i. The teaching of medical professionalism needs to be reframed from a list of values and attitudes to focus on observable, measurable, behaviors.
  - ii. Teaching of medical professionalism must evolve to include guidelines on digital media and social networking for students, residents, and practicing physicians.
  - iii. The Royal College must collaborate with LCME, AFMC, CFPC and provincial/territorial colleges to ensure that definitions of medical professionalism are comprehensive and uniformly applied across the continuum of medical education and practice.
  - iv. The Royal College should invest in development of teaching programs on professionalism (including content on physician wellness, physician impairment, and lifelong learning, and how to recognize and remediate physicians with professionalism deficiencies).
- c. *Assessment of Medical Professionalism*
  - i. The teaching of medical professionalism must be accompanied by formal assessment of professional behaviors.
  - ii. The Royal College should initiate collaboration with the AFMC, CFPC, and provincial/territorial licensing bodies to develop a formal document detailing Milestones of Professional Behavior
  - iii. The Royal College Assessment Tools Handbook should be updated, and ultimately developed further into individual resources for assessment of each of the core competencies, including medical professionalism
  - iv. Application of validated instruments for the formal assessment of post-graduate trainees' professional behaviors should be encouraged in residency programs, but also at the undergraduate and practicing physician level
  - v. The Royal College, in collaboration with other medical governing bodies should develop a 'tool kit' resource for remediation interventions for use by teachers, faculties of medicine, and licensing bodies.
- 2. Professional Faculty Development teaching/training on Medical Professionalism should be mandatory for members of all Faculties of Medicine
  - i. The Royal College should collaborate with LCME and provincial/territorial licensing bodies to ensure that Faculties of Medicine are adequately defining and assessing professional behaviors of all physicians.
  - ii. Maintenance of Certification in areas relating to medical professionalism should be a requirement for all participants in the Royal College MOC program.
  - iii. The Royal College should collaborate with provincial and territorial licensing bodies, the CMA, CMPA, and AFMC to identify, develop, and disseminate resources, which address issues of physician wellness, and dealing with impaired and disruptive physicians.
- 3. The Royal College should stay abreast of evolving areas in medicine and society that will impact the conceptualization of medical professionalism in future.

- a. *Digital Media and Social Networking*
  - i. The Royal College should participate in a collaboration with the relevant certifying, educating, and regulatory bodies in medicine in Canada to develop guidelines with respect to professional behaviors relating to the use of the internet, e-mail, and social networking where it pertains to medical practice and patient care.
- b. *Evolution of Medical Technologies and Current Thinking*
  - i. The Royal College should participate with the appropriate governing and educational bodies in medicine for purposes of consensus building around ethical dilemmas that arise from evolving medical technologies and debates.
  - ii. The Royal College should play a key role in disseminating resources to assist in the teaching of these topics to medical trainees, and for continuing professional development in these areas for physicians in practice (through links with the Maintenance of Certification Program).

## 5. Professionnalisme

Livre blanc préparé pour le Collège royal des médecins et chirurgiens du Canada :  
L'avenir de l'éducation médicale au Canada

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### Sommaire des principaux enjeux

- Le professionnalisme médical constitue le fondement de tous les aspects entourant l'enseignement et l'exercice de la médecine.
- Le professionnalisme médical est une compétence individuelle formée et éclairée par les cultures institutionnelles, systémiques et sociales qui peuvent en favoriser ou en empêcher le développement et l'expression; par conséquent, le contexte culturel doit être reconnu et compris.
- Les défis relatifs au changement et les catalyseurs comprennent notamment :
  - les attentes de la société;
  - les modèles de soins concertés;
  - les taux croissants de plaintes pour fautes professionnelles;
  - les taux élevés d'erreurs médicales;
  - les taux d'incapacité de médecins à la pratique sécuritaire en raison d'un handicap et de problèmes de santé mentale;
  - les progrès de la technologie et des sciences médicales;
  - le cyberprofessionnalisme;
  - les perceptions négatives du professionnalisme parmi les médecins en formation;
  - la menace à l'autoréglementation;
  - les politiques sur les conflits d'intérêts.

### Sommaire des recommandations

1. Le professionnalisme doit demeurer un pivot de la formation médicale postdoctorale.
  - a. *Agrément*
    - i. Les normes d'agrément du Collège royal doivent maintenir l'obligation de l'enseignement et de l'évaluation du professionnalisme médical en tant que composantes fondamentales dans toutes les phases des programmes de formation des résidents.

- ii. Le Bureau de l'éducation du Collège royal devrait assumer un rôle actif dans la diffusion de ressources d'enseignement appropriées et efficaces sur le professionnalisme pour les programmes de formation des résidents.
  - iii. Le Collège royal devrait prendre l'initiative de collaborer avec d'autres organismes d'agrément afin de favoriser l'élaboration et la mise en œuvre de méthodes d'enseignement valables sur le plan pédagogique et de mécanismes rigoureux d'évaluation du professionnalisme dans tout le continuum de la formation médical.
- b. *Enseignement du professionnalisme médical*
- i. L'enseignement du professionnalisme médical doit être redéfini à partir d'une liste de valeurs et d'attitudes afin de cibler des comportements observables et mesurables.
  - ii. L'enseignement du professionnalisme médical doit évoluer pour incorporer des lignes directrices concernant les médias numériques et le réseautage social à l'intention des étudiants, des résidents et des médecins en exercice.
  - iii. Le Collège royal doit collaborer avec le Liaison Committee for Medical Education (LCME), l'Association des facultés de médecine du Canada (AFMC), le CMFC et les collèges provinciaux et territoriaux pour veiller à ce que les définitions du professionnalisme médical soient exhaustives et qu'elles soient appliquées uniformément dans le continuum complet de la formation médicale et de l'exercice de la profession.
  - iv. Le Collège royal devrait investir dans l'élaboration de programmes d'enseignement sur le professionnalisme (comprenant du contenu sur le mieux-être des médecins, l'incapacité des médecins à la pratique sécuritaire en raison d'un handicap, l'apprentissage continu ainsi que des façons de découvrir et de soutenir les médecins ayant des déficiences professionnelles).
- c. *Évaluation du professionnalisme médical*
- i. L'enseignement du professionnalisme médical doit être accompagné d'une évaluation formelle des comportements professionnels.
  - ii. Le Collège royal devrait amorcer une collaboration avec l'AFMC, le CMFC et les organismes provinciaux et territoriaux de délivrance des permis d'exercice pour élaborer un document formel présentant en détail les jalons du comportement professionnel.
  - iii. Le *Guide des outils d'évaluation* du Collège royal (Bandiera et coll., 2006) devrait être mis à jour et ultimement augmenté en ce qui a trait aux ressources individuelles pour l'évaluation de chacune des compétences fondamentales, y compris le professionnalisme médical.
  - iv. L'application d'instruments validés pour l'évaluation formelle des comportements professionnels des médecins en formation postdoctorale devrait être encouragée dans les programmes de résidence, mais aussi l'évaluation de ceux des étudiants du baccalauréat et des médecins en exercice.
  - v. Le Collège royal, en collaboration avec d'autres organismes régissant l'exercice de la médecine, devrait élaborer une boîte à outils pour les interventions visant à apporter des mesures correctives, qui pourrait être utilisée par les enseignants, les facultés de médecine et les organismes de délivrance des permis d'exercice.

2. L'enseignement et la formation sur le professionnalisme médical dans le cadre des programmes de perfectionnement des corps professoraux devraient être obligatoires pour tous les membres des facultés de médecine.
  - i. Le Collège royal devrait collaborer avec le LCME et les organismes provinciaux et territoriaux de délivrance des permis d'exercice pour veiller à ce que les facultés de médecine définissent et évaluent adéquatement les comportements professionnels de tous les médecins.
  - ii. Le maintien du certificat dans des domaines liés au professionnalisme médical devrait constituer une exigence pour tous les participants au programme de MDC du Collège royal.
  - iii. Le Collège royal devrait collaborer avec les organismes provinciaux et territoriaux de délivrance des permis d'exercice, l'AMC, l'ACPM et l'AFMC pour déterminer, concevoir et diffuser des ressources portant sur le mieux-être des médecins et sur les façons de traiter avec les médecins hors d'état d'exercer en toute sécurité en raison d'un handicap et les médecins aux comportements perturbateurs.
3. Le Collège royal devrait se tenir au fait des domaines évolutifs de la médecine et de la société qui influenceront sur la conceptualisation du professionnalisme médical dans l'avenir.
  - a. *Médias numériques et réseautage social*
    - i. Le Collège royal devrait collaborer avec les organismes pertinents de certification, d'éducation et de réglementation en médecine au Canada afin d'élaborer des lignes directrices sur les comportements professionnels liés à l'usage de l'Internet et du courrier électronique ainsi qu'à la participation à des réseaux sociaux en ce qui a trait à l'exercice de la médecine et des soins aux patients.
  - b. *Évolution des technologies médicales et opinion actuelle*
    - i. Le Collège royal devrait participer avec les organismes d'éducation et de réglementation en médecine dans le but de rechercher un consensus sur les dilemmes déontologiques émanant des technologies en évolution et des débats dans le domaine de la médecine.
    - ii. Le Collège royal devrait jouer un rôle clé dans la diffusion de ressources pour assister l'enseignement de ces sujets aux médecins en formation ainsi que pour le développement professionnel continu dans ces domaines pour les médecins en exercice (par l'intermédiaire de liens avec le programme de Maintien du certificat).

# Professionalism

## Context/Purpose

This White Paper on the Future of Medical Education is intended to address key elements relating to the teaching and assessment of medical professionalism. Medical professionalism is fundamental to all aspects of the teaching and practice of medicine, and as such deserves special consideration in looking to the future of medical education from the post-graduate education perspective.

As the certifying body for specialist physicians in Canada, it will be essential for the Royal College to take a leading role in shaping post-graduate education and assessment of medical professionalism.

To address this topic we have focused on the core elements that are essential to developing and maintaining medical professionalism as a central tenet of medical education, societal needs and expectations and the evolving delivery of health care in the 21<sup>st</sup> century.

While for the purposes of this paper professionalism is an individual competency, it must be kept in mind that this competency is formed and informed by institutional, systemic and societal cultures that can nurture or impede its development and expression, and thus the cultural context must be acknowledged and understood. The interplay between the many social, cultural, systemic, organizational, and individual elements comprising our conceptualization of medical professionalism is extremely complex and multilayered. To aid in developing an understanding of the different facets we have included a visual representation in the form of a concept map found in Appendix A.<sup>1</sup>

## Scope

This White Paper lays out the key definitions of medical professionalism, and highlights key concepts that relate to the teaching and assessment of professionalism within post-graduate medical education. We have included new issues, as well as the traditional concepts of medical professionalism. In particular, this White Paper will touch on the issues relating to altruism, ethics, professional autonomy, digital communication and social networking, and physician wellness. In addition, we address challenges of teaching medical professionalism, which relate to learner perceptions of professionalism, and professionalism teaching. We

highlight areas of emphasis and potential resources to guide residency educators and physician teachers in innovation and implementation of curricula for this core component of training.

While the paper is directed towards education at the post-graduate level, it is recognized that the core content is no less germane to all levels of medical education from the undergraduate level through post-graduate medical education to the education of those in practice.

## Background

There is a rich literature around definitions, teaching and assessment of medical professionalism. Before exploring the aspects of this domain that are essential considerations in envisioning the future of post-graduate medical education, it is important to the current definitions of “profession” and “medical professionalism”. We begin with the definition of a profession. Next, we lay out definitions of medical professionalism from three influential documents in the professionalism literature, including the the work of Canadian experts on professionalism, Drs. Richard and Sylvia Cruess, the American Board of Internal Medicine Physician Charter, the Association of American Medical Colleges’ Medical School Objectives Project, and the CanMEDS Framework<sup>2, 3, 4, 5</sup>. It is important to include all of these definitions, as they have each been influential in shaping medical education on professionalism, and they vary in their focus on values, attitudes, principles, and responsibilities underpinning professionalism. We also reference the recent work of Cooke et al., who re-frame the concepts as “professional formation”<sup>6</sup>, and of Lesser et al., who identify *specific behaviours* that encompass professionalism both on the part of *individual physicians, and organizations and healthcare systems*.<sup>7</sup>

The term profession is often defined broadly to include the concepts of altruism, and a specialized body of knowledge. Cruess et al. proposed a more extensive definition of the term “Profession”, to include the importance of the societal contract and self-regulation.<sup>2</sup> Their definition of a profession is as follows:

*An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded*

*upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly of the use of its knowledge base, and the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society.*<sup>2</sup>

Professionalism, by extension, is defined by Cruess et al. as the “list of attributes, characteristics, or behavioural patterns” that are expected from one who practices in a profession (a “professional”).<sup>2</sup>

The definition of medical professionalism is further delineated, as principles and responsibilities, by the American Board of Internal Medicine publication, “Medical Professionalism in the New Millennium: A Physician Charter”.<sup>3</sup> This document highlights three principles of medical professionalism; i) primacy of patient welfare, ii) patient autonomy, and iii) social justice. The document also includes ten professional responsibilities consisting of commitment to each of the following:

- i. professional competence
- ii. honesty with patients
- iii. patient confidentiality
- iv. maintaining appropriate relations with patients
- v. improving quality of care
- vi. improving access to care
- vii. just distribution of finite resources
- viii. scientific knowledge
- ix. maintaining trust by managing conflicts of interest
- x. professional responsibilities.

In their report of the Medical School Objectives Project (MSOP), the Association of American Medical Colleges defines professionalism on the basis of four over-arching *attributes*; knowledge, skill, altruism, and duty.<sup>4</sup>

The CanMEDS Framework of Physician Competencies outlines *key competencies* for the Role of Medical Professional as follows<sup>5</sup>:

Physicians are able to:

1. Demonstrate a commitment to their patients, profession, and society through their ethical practice.
2. Demonstrate a commitment to their patients, profession, and society through participation in profession-led regulation.
3. Demonstrate a commitment to physician health and sustainable practice.

In a recent publication sponsored by the Carnegie Foundation for the Advancement of Teaching, Cooke et al. make further distinctions relating to medical professionalism:

*We prefer the term **professional formation** to professionalism to underline the continuous, dynamic, multifaceted, and profound nature of the construct. Building on an essential foundation of clinical competence, communication and interpersonal skills, and ethical and legal understanding, professional formation necessarily extends to aspirational goals in performance, excellence, accountability, humanism, and altruism<sup>6</sup>*

We also emphasize that residents must attain medical expert competence as well competence in all other attributes (CanMEDS competencies) and have a commitment to life-long learning. Cooke et al. refer to this as "aspirational goals of excellence, accountability, humanism, altruism and continued progress toward expertise after completion of training".<sup>6</sup>

The authors highlight challenges to professional formation which include: lack of clarity and focus on professional values; failure to assess knowledge and advanced professional behaviors; in-adequate expectations for progressively higher levels of professional commitment; and, erosion of professional values because of pace and commercial nature of health care. They also provide recommendations to enhance the professional formation process including: promote formal ethics instruction; address the underlying messages in the hidden curriculum; offer feedback opportunities for reflection and assessment of professionalism in the context of longitudinal mentoring; promote relationships with faculty who simultaneously support learners and hold them to high standards; and, create collaborative learning environments committed to excellence and continuous improvement.

## Challenges and Drivers for Change:

Both the challenges and drivers for changing professionalism are complex and have evolved significantly over the past two decades. They include:

- Societal Expectations
  - Public expectations are constantly evolving and growing in concert with the ease of access to medical information through the media, internet, and other resources.
- Collaborative Care Models
  - Issues of sustainability of the health care system and limited healthcare resources coupled with increasing patient complexity have led to new, multidisciplinary and team-based models of health care delivery. These models of practice require physicians to be skilled in teamwork and interprofessional collaboration (see Recommendation VIII: Advance Inter-and Intraprofessional Practice<sup>8</sup>)
- Rising malpractice complaint rates.
- Increasing recognition of medical error
  - Publications of high rates of in-hospital morbidity and mortality due to medical error have generated a mandate within the profession and outside of it to increase safety and accountability in the practice of medicine and within healthcare delivery systems. This represents an evolving area of required physician competence encompassing quality improvement skills as well as the skills and obligations inherent in error disclosure, and transparency.
- Rates of physician impairment and mental health issues
  - Risk management initiatives, patient safety initiatives, and improved physician regulation and monitoring have focused attention on issues surrounding physician impairment and mental health issues, which occur with higher frequency in medicine than in the general population. This raises an important issue: emphasis on physician wellness can be at odds with the tenet of altruism. This tension is further heightened in the setting of overburdened health care systems, shortened resident duty hours, a sicker, aging population, and resultant higher clinical and educational demands. Attitudes to these same issues may contribute to tensions between generations of physicians in practice and in training.
- Advances in technology and medical science

- Exponential growth in medical knowledge and diagnostic capabilities has raised complex ethical issues within certain areas, including end-of-life care, genetics testing, stem-cell research.
- E-Professionalism
  - Several key issues relating to computers and the internet have created new challenges to the traditional constructs of medical professionalism:
  - For example:
    - the enduring nature of on-line and e-mail communication can result in continued dissemination of material beyond the author's intended audience long after the author may have changed the expressed opinion. This is particularly relevant for material generated in a trainee's formative years when their judgment had not fully matured
    - the balance of how social networking sites can be used as an educational resource, and forum for communication vs. a forum that can reveal open displays of unprofessional conduct<sup>9, 10, 11</sup>
    - confidentiality issues relating to communication with patients via e-mail, response-times, firewalls and patient treatment blogs
- Negative perceptions of Professionalism amongst trainees
  - There is a perception of learners that it is their sole responsibility to develop and demonstrate professional behaviours in the face of glaring conflicts between professional principles and witnessed behaviours of role models. Learners also perceive that health care systems and the profession as a whole have abrogated responsibility for making changes that address systemic problems at odds with the principles of professional behaviour.<sup>7, 12</sup>
- Threat to self-regulation
  - Self-regulation is a central tenet of the definition of a profession, however it is both a privilege and a responsibility of the members of the profession.
  - Several factors may pose a threat to self-regulation of the medical profession, including:
    1. Increasingly restrictive practices by physicians, limiting physician availability to meet the obligations of our social contract
    2. This may lead to a perception that physicians are collectively failing to meet societal obligations

3. The need for sustainability of the health care system, and cost-containment and the resultant move for funding bodies to play a greater regulatory role
  4. Public perception of colleges and governing bodies in medicine as guardians for physicians ('circling the wagons'), rather than of the profession in its role for the good of society
- Conflict of Interest Policies
    - Academic institutions, industry sponsors, regulatory bodies, and the public have heightened awareness of issues of trust and honesty that could be adversely affected by industry involvement in research and education. This poses challenges and ethical dilemmas wherever funding of educational programs is supported by the pharmaceutical industry.

## Recommendations for Post-Graduate Education in Medical Professionalism

### 1. Professionalism must remain a central tent of post-graduate medical education.

#### *a. Accreditation:*

- i. The Royal College accreditation standards must maintain the mandate of teaching and assessment of medical professionalism as core components in all phases of residency-training programs. *This should include assessment of policies and teaching activities directed at resident wellness.*
- ii. The Royal College Office of Education should take an active role in disseminating appropriate, effective teaching resources on professionalism for residency training programs. This will require ongoing support, and strengthening of the resources available within the Royal College to identify and/or develop and then disseminate effective teaching programs/methods. Dissemination should be to Post-Graduate Deans, and residency program leaders, but also to other credentialing bodies across the continuum of medical education from undergraduate learners to those in practice.
- iii. The Royal College should take a lead in collaborating with other credentialing bodies, including CFPC and LCME in order to foster development or identification and implementation of educationally sound teaching methods and rigorous assessment methods for medical professionalism across the continuum of medical education from undergraduate to physicians in practice (see Faculty Development, below, for implications for Maintenance of Certification).

#### *b. Teaching of Medical Professionalism*

- i. *The teaching of medical professionalism needs to be reframed* from a list of values and attitudes which are difficult to assess to focus on observable, measurable, behaviors that demonstrate professionalism<sup>7</sup> and can be used as benchmarks for learners and teachers alike.

This 're-framing' of how professionalism is taught in many centers may lead to greater buy-in on the part of students and residents, and may help to align what is taught with what is observed by learners in their day-to-day interactions with practicing physicians. Examples of the behaviors related to specific values that are emblematic of medical professionalism are shown in Appendix B

- ii. Teaching of medical professionalism must evolve to include *guidelines on digital media and social networking* for students, residents, and practicing physicians (see Evolving Areas, below).
- iii. The Royal College must collaborate with LCME, AFMC, CFPC and provincial/territorial colleges to ensure that definitions of medical professionalism are comprehensive, and uniformly applied across the continuum of medical education and practice, such that teaching and learning of professional behaviors is consistent from one stage of training to the next.
- iv. The Royal College should invest in development of teaching programs on professionalism (including content on physician wellness, physician impairment, and lifelong learning, and how to recognize and remediate physicians with professionalism deficiencies). These should be targeted at resident leaders, and physician-teachers in order to disseminate the definitions and understanding of professional behaviors at a national level.
- v. The Royal College should partner with the AFMC, CFPC and provincial/territorial licensing bodies to develop programs of remediation for learners and those in practice who are identified as having deficiencies in professionalism.

c. *Assessment of Medical Professionalism*

- i. The teaching of medical professionalism must be accompanied by formal assessment of professional behaviors. It is essential that this occur throughout the continuum of medical education and practice, in order to ensure that practicing physicians, who are role models to learners, operate under the same rubric of professionalism that is taught at the undergraduate and post-graduate levels.
- ii. The Royal College should initiate collaboration with the AFMC, CFPC, and provincial/territorial licensing bodies to develop a formal document detailing Milestones of Professional Behavior. This should include the resources for assessment and teaching of professional behaviors across the continuum of medical education. The Royal College will need to take a leadership role in disseminating the Milestones document once it is completed.

- iii. The Royal College has taken some initiative in this regard, with the publication of the Assessment Tools Handbook.<sup>13</sup> This document should be updated, and ultimately developed further to provide individual resources for assessment of each of the core competencies, including medical professionalism. Emphasis should be placed on direct observation for the assessment of professionalism.
- iv. Formal assessment of post-graduate trainees' professional behaviors is mandated through the current accreditation guidelines. Application of validated instruments for this assessment should be encouraged in residency programs, but also at the undergraduate and practicing physician level. The assessment methods employed need to be sufficiently robust to fail a resident who behaves unprofessionally, despite their medical expertise.<sup>14, 15, 16</sup>
- v. The Royal College, in collaboration with other medical governing bodies should develop a 'tool kit' resource for remediation interventions for use by teachers, faculties of medicine, and licensing bodies.

**2. Professional Development is a critical component of enhancing the teaching and assessment of medical professionalism across the continuum of medical education and practice [See Faculty Development Re-Imagined white paper].**

- a. *Faculty Development teaching/training on Medical Professionalism should be mandatory for members of all Faculties of Medicine.*
  - i. In order to foster effective teaching and assessment of professional behaviors, Faculty Development will be essential for medical teachers. LCME and Royal College Accreditation Standards must mandate access and physician support (recognition for promotion, protected time, remuneration for time) for such Faculty Development programs.
- b. *Faculty development addressing on medical professionalism must include:*
  - i. Clear definitions of the terms profession and medical professionalism that are accompanied with concrete examples of behaviours that must be demonstrated by the medical professional and by medical professional organizations<sup>7</sup>
  - ii. A model that encourages behaviors to be taught along an uninterrupted, developmental continuum beginning with undergraduate medical students, and progressing into practice.
  - iii. Appropriate methods for assessment of, and identification of deficiencies in medical professionalism in formal and informal settings.<sup>14, 15, 16</sup>
  - iv. Tools for addressing identified gaps in medical professionalism.
  - v. Clear standards for practicing physicians, that mirror the standards defined for trainees.
  - vi. Standards and guidelines regarding use of digital media and social networking in the medical milieu (See Evolving Areas, below).
- c. *The Royal College should collaborate with LCME and provincial/territorial licensing bodies to ensure that Faculties of Medicine are adequately defining and assessing professional behaviors of all physicians.*

- d. *Maintenance of Certification in areas relating to medical professionalism should be a requirement for all participants in the Royal College MOC program. Maintenance of Certification for physicians should be tailored to relevant aspects of professionalism specific to the physician's role in clinical practice and as a teacher.*
- e. *The Royal College should collaborate with provincial and territorial licensing bodies, the CMA, CMPA, and AFMC to identify, develop, and disseminate resources, which address issues of physician wellness, and dealing with impaired and disruptive physicians. Availability of such resources to residents and to physician-teachers should be an Accreditation requirement.*

### **3. Evolving Areas in Medical Professionalism**

The Royal College needs to stay abreast of evolving areas in medicine and society that will impact the conceptualization of medical professionalism in future. Current examples are the impact of digital media, and the ethical dilemmas that arise out of stem cell research, and diagnostic modalities and end-of-life care, as outlined below.

As leaders in post-graduate medical education, the Royal College is poised to develop and collaborate on appropriate, relevant guidelines to address evolving issues affecting medical practice. The Royal College should endeavour to take a pioneering and leadership role in guiding the profession as new areas arise in the years to come.

#### *a. Digital Media and Social Networking*

The Royal College should participate in a collaboration with the relevant certifying, educating, and regulatory bodies in medicine in Canada to develop guidelines with respect to professional behaviors relating to the use of the internet, e-mail, and social networking where it pertains to medical practice and patient care. These guidelines should be disseminated to all practicing physicians, and adopted by Faculties of Medicine and provincial licensing bodies in Canada. The guidelines should be incorporated into the descriptions of professional behaviors expected of competent physicians.

#### *b. Evolution of Medical Technologies and Current Thinking*

The Royal College should participate with the appropriate governing and educational bodies in medicine for purposes of consensus building around ethical dilemmas that arise from evolving medical technologies and debates, such as stem cell research, end-of-life care, use of diagnostic tests, etc.

The Royal College should play a key role in disseminating resources to assist in the teaching of these topics to medical trainees, and for continuing professional development in these areas for physicians in practice (through links with the Maintenance of Certification Program).

## References

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## Appendix A.1: Professionalism Concept Map – Overview cont'd

### Professionalism

#### I. Curriculum Structure

##### A. Learner Differences

1. specialty
2. hierarchy
3. generation

##### B. Situated Learning

1. Experiential Learning
2. Role Modelling
  - a. Clinical Competence
  - b. Teaching Skills
  - c. Personal Qualities
  - d. Interprofessional Relations
3. Self Reflection
4. Supportive Environment
5. Cognitive Base

##### C. Continuity

1. Graduated Learning
2. Self / Peer Evaluation
3. Early/Ongoing Clinical Experience

##### D. Collaborative

1. Share Curricula
2. Intraprofessional
3. Interprofessional

##### E. Make Implicit Explicit

1. Values
2. Attitudes
3. Belief

#### II. Definition of Professionalism

##### A. Social contract

1. Social Responsibility/Accountability
  - a. Individual Physicians
  - b. Institutions
  - c. Professional Bodies

##### B. Social Change

1. Diversity
2. Socioeconomic Disparity
3. Connectivity
  - a. Public Access 2Knowledge
  - b. e-professionalism

##### C. Healer/Professional

##### D. RCPS

#### 1. Promotion of Public Good

#### 2. Clinical Competency

#### 3. FMEC I

- a. Address Individual/Community Needs

#### 4. FMEC V

- b. Promote Prevention & Public Health

#### 5. FMEC VIII

- a. Advance Inter-and Intraprofessional Practice

#### III. Curriculum

##### A. Internet based

1. Wikis
2. Online Avatars
3. Chatrooms
4. Facebook

##### B. Formal / Informal / Hidden

##### C. Assessment

1. CIT
2. P-MEX
3. 360
4. Portfolio
5. ITER/Direct Observation

##### D. Adult Learning Principles

##### E. Situated Learning

1. Articulation
  - a. Component Separation to aid learning
  - b. Articulate Knowledge, reasoning, problem solving Processes
  - c. Make Learning Visible
2. Skill Practice
  - a. Extend . Test
  - c. Refine / Embed
3. Reflection
  - a. IN Action
  - b. ON Action
  - c. FOR Action
4. Collaborative Learning
5. Cognitive Apprenticeship
  - a. Modelling=>Scaffolding=>Fading

#### b. Coaching

#### IV. Interprofessional

##### A. Different Professions

1. Medicine
2. Community Partners
3. Hospital Based Professionals
4. Nursing

##### B. IPE

##### C. FMCVIII

#### V. Faculty Development

##### A. Organizational Level

1. Core Content
2. Define Shared Vision
  - a. Champions
  - b. Create Opportunities
3. Address Systems Issues
4. Remediation

##### B. System Level

1. Promote Buy In
  - a. Time
  - b. Human Resources
  - c. \$\$\$\$
  - d. Remediation
2. Specialty Specific Issues
3. Identify Opportunities for Team Learning
4. Organizational Culture

##### C. Individual Level

1. Develop Skills
2. Build motivation
3. Provide Tools/Content

#### VI. Threats to Professionalism

##### A. Commodification of Healthcare

##### B. Questioning Society

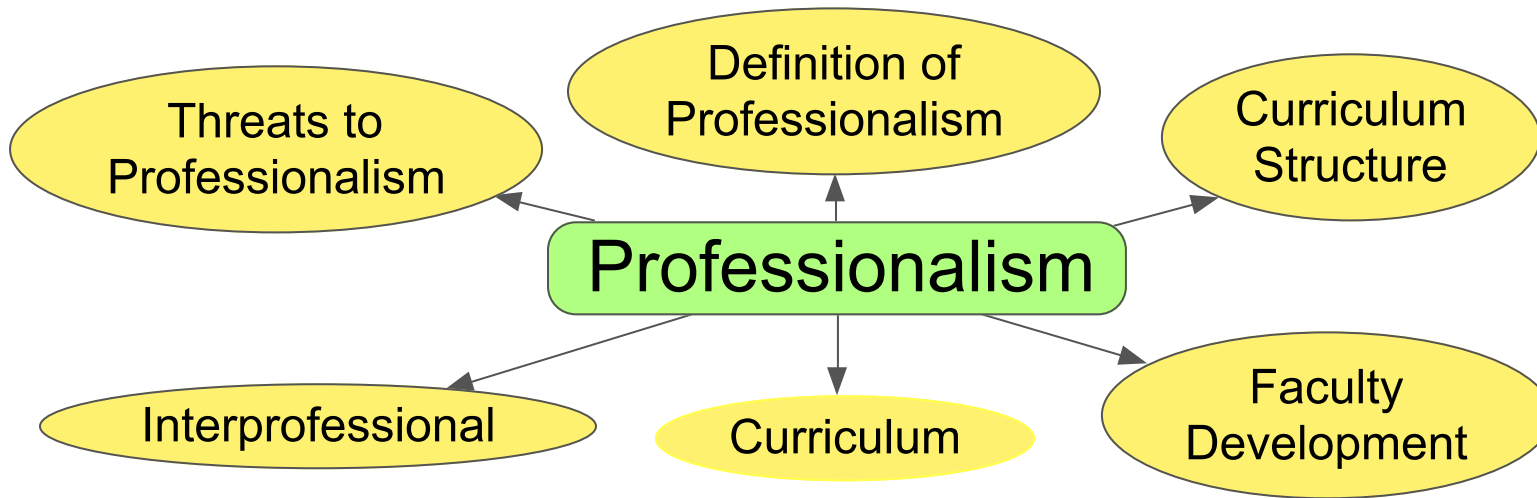
1. Internet
2. Distrust of Authority

##### C. Complex Healthcare system

##### D. Failure of Medicine to Meet Obligations

1. Lack of Attention to Social Justice

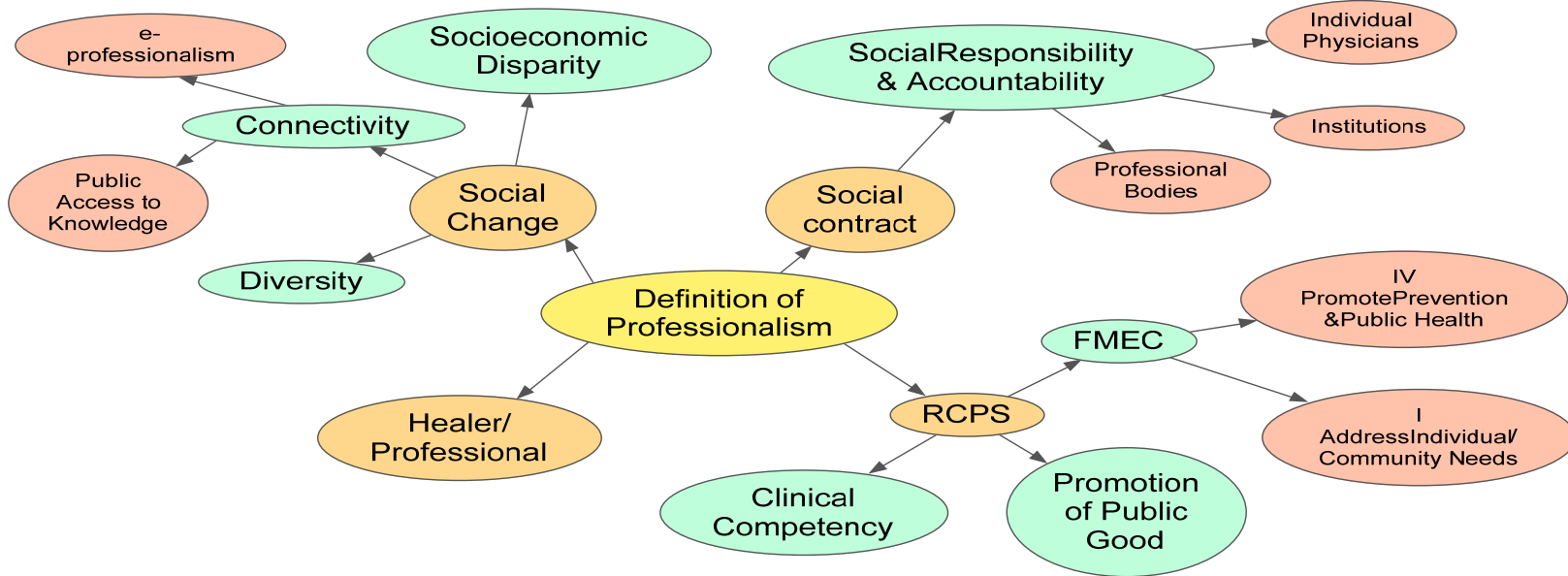
Appendix A.2: Professionalism Concept Map – Expanded View



**Professionalism**

- I. Definition of Professionalism
- II. Curriculum
- III. Interprofessional
- IV. Threats to Professionalism
- V. Curriculum Structure
- VI. Faculty Development

Appendix A.2: Professionalism Concept Map – Expanded View cont'd



**Definition of Professionalism**

I. Royal College

- A. Promotion of Public Good
- B. Clinical Competency
- C. FMEC
  - FMEC IV Promote Prevention & Public Health
  - FMEC I Address Individual/Community Needs

II. Healer/Professional

III. Social contract

- A. Social Responsibility & Accountability
  - 1. Individual Physicians
  - 2. Institutions
  - 3. Professional Bodies

IV. Social Change

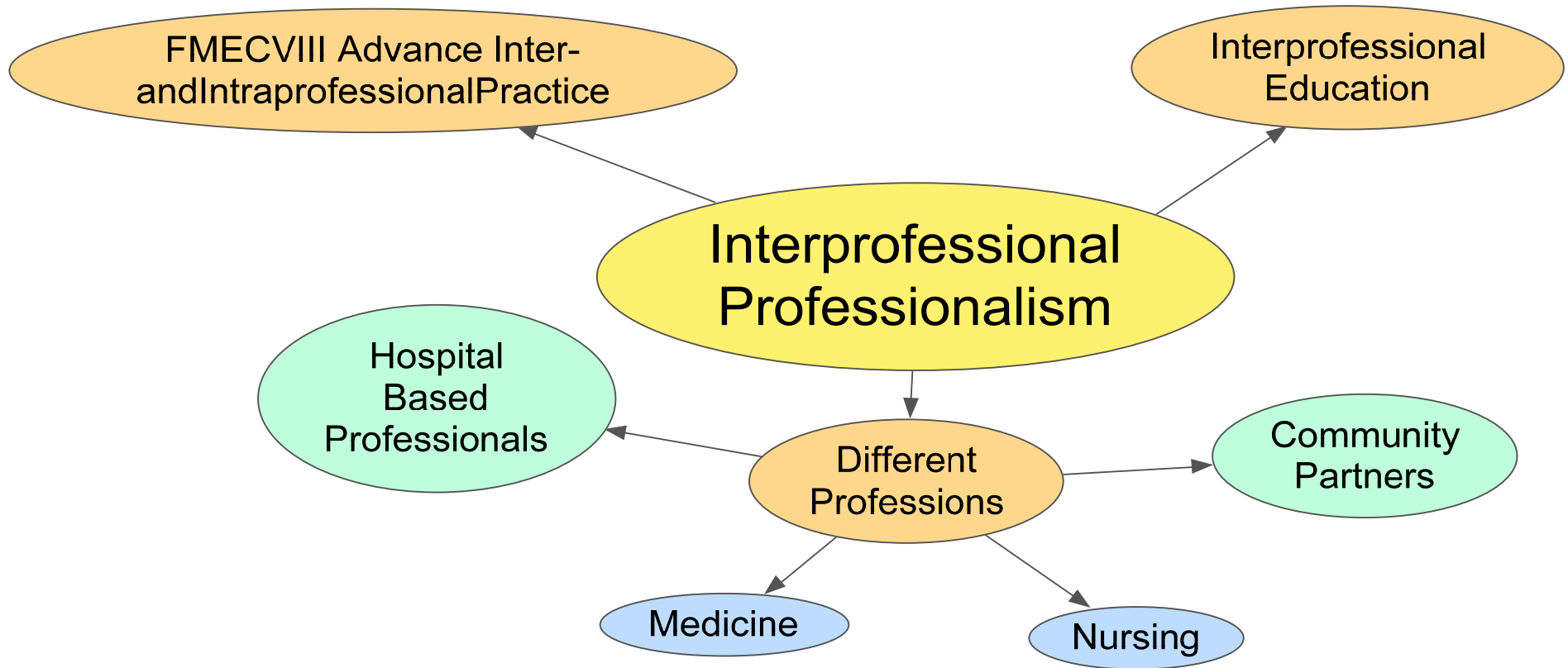
- A. Diversity
- B. Socioeconomic Disparity
- C. Connectivity
  - Public Access to Knowledge
  - e-professionalism



**Threats to Professionalism**

- I. Commodification of Healthcare
- II. Complex Healthcare system
- III. Questioning Society
  - A. Internet
  - B. Distrust of Authority
- IV. Failure of Medicine to Meet Obligations
  - A. Lack of Attention to Social Justice

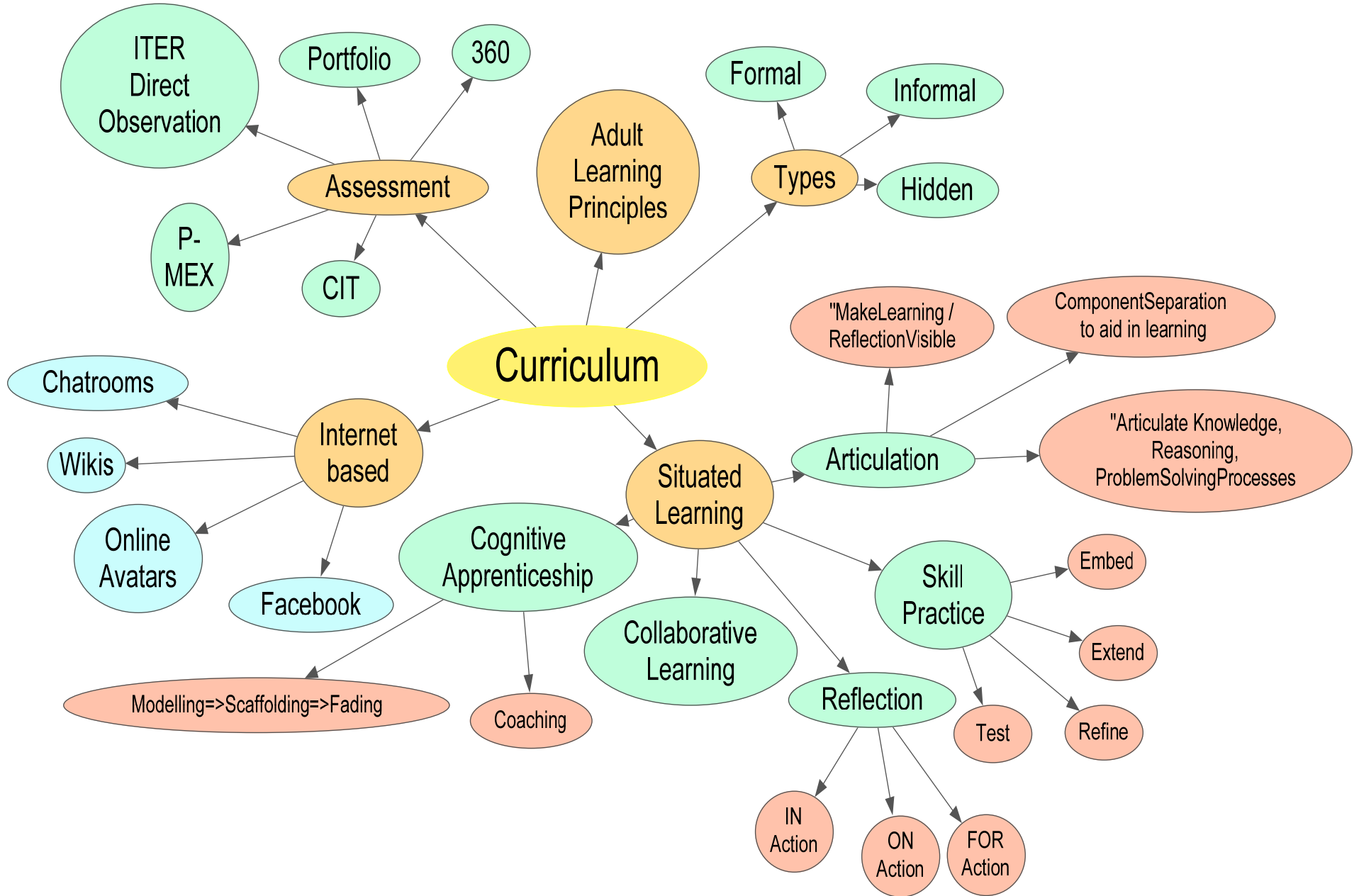
Appendix A.2: Professionalism Concept Map – Expanded View cont'd



**Interprofessional Professionalism**

- I. Interprofessional Education
- II. FMECVIII Advance Inter-and Intraprofessional Practice
- III. Different Professions
  - A. Medicine
  - B. Nursing
  - C. Hospital Based Professionals
  - D. Community Partners

Appendix A.2: Professionalism Concept Map – Expanded View cont'd



## Appendix A.2: Professionalism Concept Map – Expanded View cont'd

### Curriculum

#### I. Types

- A. Formal
- B. Informal
- C. Hidden

#### II. Internet based

- A. Wikis
- B. Online Avatars
- C. Chat rooms
- D. Facebook

#### III. Adult Learning Principles

#### IV. Assessment

- A. CIT
- B. P-MEX
- C. 360
- D. Portfolio
- E. ITER /Direct Observation

#### V. Situated Learning

##### A. Articulation

1. Articulate Knowledge, Reasoning, Problem Solving Processes
2. "Make Learning /Reflection Visible"
3. Component Separation to aid learning

##### B. Skill Practice

1. Extend Skills
2. Test Skills
3. Refine Skills
4. Embed Skills

##### C. Cognitive Apprenticeship

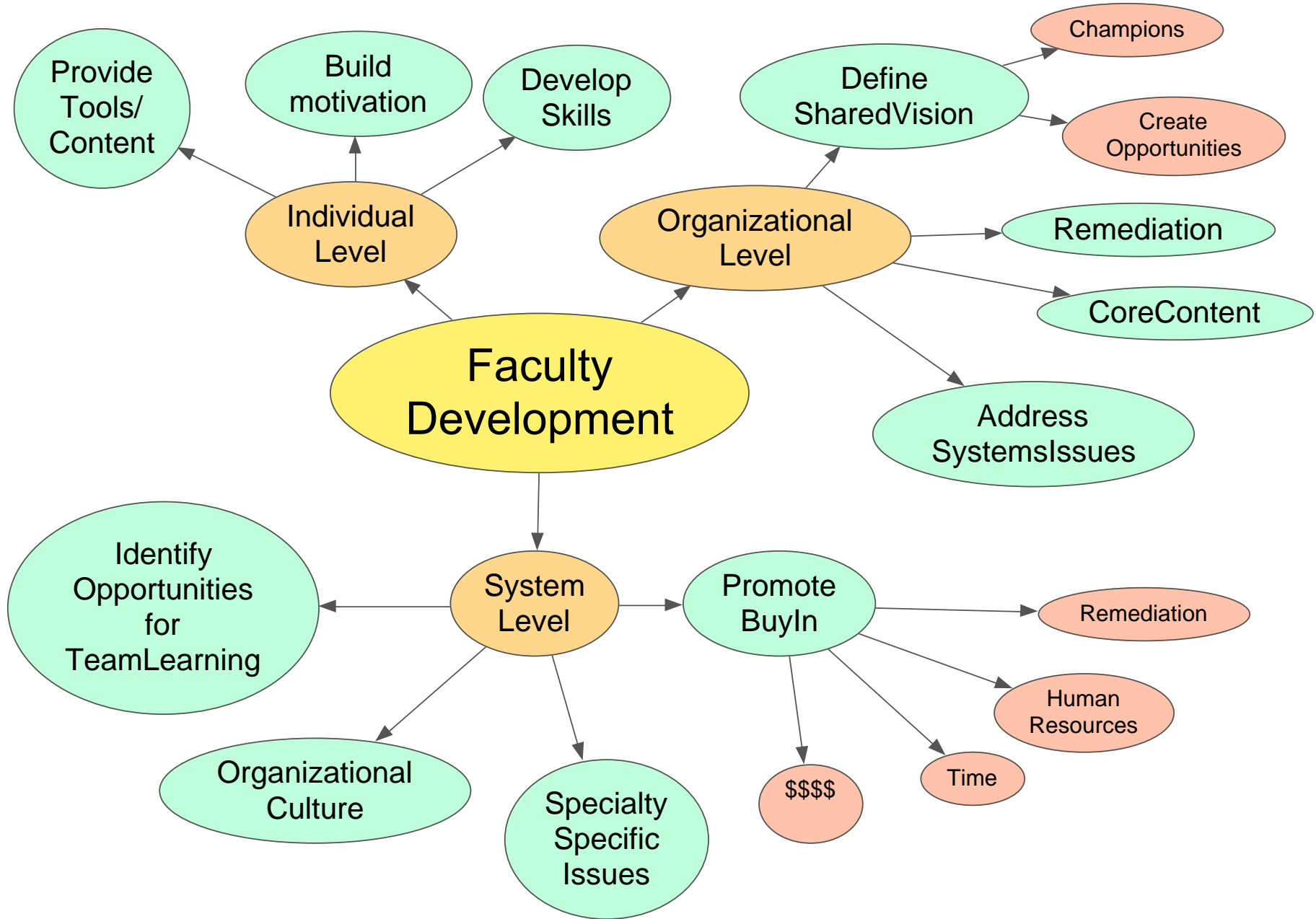
1. Modelling=>Scaffolding=>Fading
2. Coaching

##### D. Collaborative Learning

##### E. Reflection

1. Reflection IN Action
2. Reflection ON Action
3. Reflection FOR Action

Appendix A.2: Professionalism Concept Map – Expanded View cont'd



## Appendix A.2: Professionalism Concept Map – Expanded View cont'd

### Faculty Development

#### I. Organizational Level

- A. Core Content
- B. Define Shared Vision
  - 1. Champions
  - 2. Create Opportunities
- C. Remediation
- D. Address Systems Issues

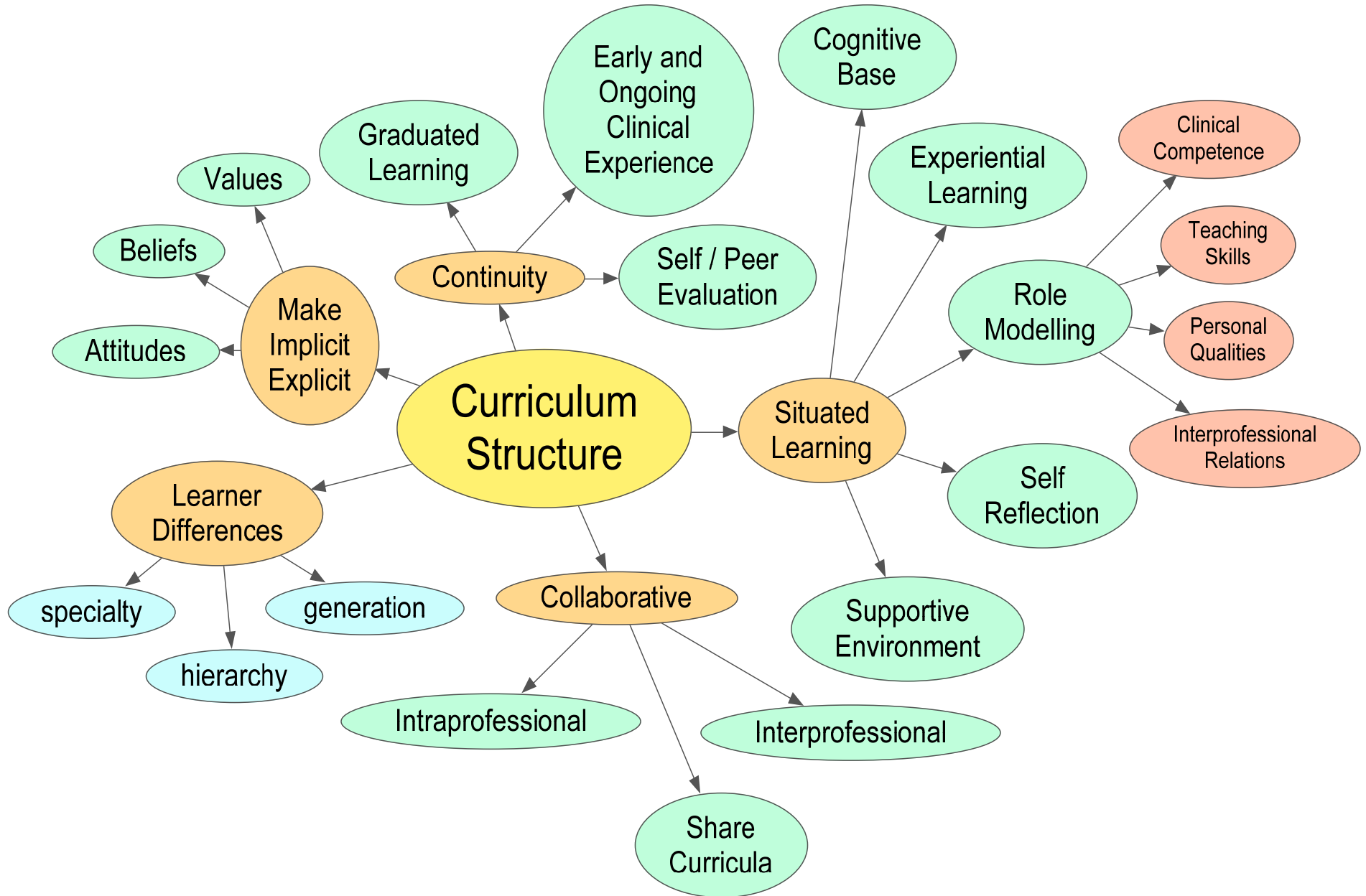
#### II. System Level

- A. Promote Buy In
  - 1. Time
  - 2. Human Resources
  - 3. \$\$\$
  - 4. Remediation
- B. Specialty Specific Issues
- C. Identify Opportunities for Team Learning
- D. Organizational Culture

#### III. Individual Level

- A. Develop Skills
- B. Build Motivation
- C. Provide Tools/Content

Appendix A.2: Professionalism Concept Map – Expanded View cont'd



## Appendix A.2: Professionalism Concept Map – Expanded View cont'd

### Curriculum Structure

- I. Learner Differences
  - A. Specialty
  - B. Hierarchy
  - C. Generation
- II. Situated Learning
  - A. Experiential Learning
  - B. Role Modelling
    - 1. Clinical Competence
    - 2. Teaching Skills
    - 3. Personal Qualities
    - 4. Interprofessional Relations
  - C. Self-Reflection
  - D. Supportive Environment
  - E. Cognitive Base
- III. Continuity
  - A. Self / Peer Evaluation
  - B. Early and Ongoing Clinical Experience
  - C. Graduated Learning
- IV. Collaborative
  - A. Share Curricula
  - B. Intraprofessional
  - C. Interprofessional
- V. Make Implicit Explicit
  - A. Values
  - B. Attitudes
  - C. Beliefs
  - D. Curriculum Structure

**Appendix B.1: Table 1. Framework for Conceptualizing Professionalism – Individual Physician Behaviors in Interactions with Patients and Family Members and Other Health Care Professionals<sup>1</sup>**

Values	Examples of Individual Physician Behaviors	
	Interactions With Patients and Family Members	Interactions With Colleagues and Other Members of the Health Care Team
Compassionate, respectful, and collaborative orientation, "in service" of the patient	<p>Provide patient-centered care, demonstrating empathy, compassion, and actively working to build rapport</p> <p>Promote autonomy of the patient; eliciting and respecting patient preferences, and including patient in decision making</p> <p>Be accessible to patients to ensure timely access to care and continuity of providers</p> <p>Act to benefit the patient when a conflict of interest exists</p>	<p>Work collaboratively with other members of the care team to facilitate effective service to the patient</p> <p>Demonstrate respect for other team members in all interactions</p>
Integrity and accountability	<p>Maintain patient confidentiality</p> <p>Maintain appropriate relationships with patients</p> <p>Promptly disclose medical errors; take responsibility for and steps to remedy mistakes</p> <p>Actively manage conflicts of interest and publicly disclose any relationships that may affect the physician's recommendations related to diagnosis and treatment (eg, part ownership of surgery center)</p>	<p>Report impaired or incompetent colleagues</p> <p>Participate in peer-review and 360-degree evaluations of team</p> <p>Specify standards and procedures for handoffs across settings of care to ensure coordination and continuity of care</p>
Pursuit of excellence	<p>Adhere to nationally recognized evidence-based guidelines (eg, guidelines issued by Agency for Healthcare Research and Quality or US Preventive Services Task Force), individualizing as needed for particular patients but conforming with guidelines for the majority of patients</p> <p>Engage in lifelong learning and professional development</p> <p>Apply system-level continuous quality improvement to patient care</p>	<p>Participate in collaborative efforts to improve system-level factors contributing to quality of care</p>
Fair and ethical stewardship of health care resources	<p>Do no harm; do not provide unnecessary or unwarranted care</p> <p>Commit to deliver care equitably, respecting the different needs and preferences of subpopulations, and to provide emergent care without regard to insurance status or ability to pay</p> <p>Deliver care in a culturally competent and resource conscious manner</p>	<p>Establish mechanisms for feedback from peers on resource use and appropriateness of care</p> <p>Work with clinical and nonclinical staff to continuously improve efficiency of care delivery process and ensure that all members of the care team are optimizing their contributions to care delivery and administration</p> <p>Actively work with colleagues to coordinate care, avoid redundant testing, and maximize prudent resource use across settings</p>

<sup>1</sup> As published in Lesser, C.S., C.R. Lucey, B. Egener, C.H. Braddock, S.L. Linas, W. Levinson. A behavioral and systems view of professionalism. JAMA 2010;304(24):2732-2737.

**Appendix B.2: Table 2 Framework for Conceptualizing Professionalism – Organizational Behaviors in Practice and Physician Advocacy and Professional Organizations<sup>2</sup>**

Values	Examples of Organizational Behaviors	
	Practice Settings (i.e. Hospitals, Health Systems, Physician Organizations)	Physician Advocacy and Professional Organizations
Compassionate, respectful, and collaborative orientation, “in service” of the patient	<p>Support ongoing development of communication skills and cultural competency to foster effective interactions with patients, families, and care team members</p> <p>Invest in shared decision-making supports and actively encourage patient engagement in care decisions</p> <p>Establish mechanisms to engage representatives of patients and family caregivers in organizational management and governance</p> <p>Adopt policies and practices that support timely access to patients’ providers of choice</p> <p>Foster creation of a physical environment that promotes healing</p>	<p>Advocate payment policy that supports clinician time with patients to build rapport, engage in shared decision making, and be accessible to patients to provide timely care</p> <p>Actively promote ongoing development of competencies related to patient engagement and teamwork</p>
Integrity and accountability	<p>Provide peer and organizational support for disclosure of medical errors and reporting impaired or incompetent clinicians</p> <p>Adopt clear and stringent policies regarding conflict of interest and maintaining patient confidentiality</p> <p>Provide performance feedback to care team and hold the team accountable for results for a defined population, eg, via compensation, public reporting, or both</p> <p>Discourage provision of services without an evidence base to support value to the patient</p>	<p>Develop and encourage organizational strategies to foster a “culture of professionalism”</p> <p>Participate in development of professional standards and establish mechanisms for remediation and discipline of members who fail to meet those standards</p> <p>Commit to disclosure of meaningful performance information</p> <p>Encourage development of systems to report and analyze medical mistakes to inform prevention and improvement strategies</p> <p>Develop conflict of interest policies</p> <p>Use benefit to patients as the metric to guide resolution of conflicts of interest</p>
Pursuit of excellence	<p>Invest in system-level supports for organization-wide quality improvement, eg, electronic health records, registries</p> <p>Establish clear targets for improvement and continuously monitor and raise the bar for performance</p>	<p>Develop and encourage use of meaningful measures of clinical quality of care and sound guidelines for clinical practice</p> <p>Establish ambitious targets and support actions to achieve significant and rapid system-wide improvements in quality of care</p> <p>Advance scientific knowledge</p>
Fair and ethical stewardship of health care resources	<p>Encourage judicious use of resources to care for a patient population, eg, by providing information on system-level costs and outcomes</p> <p>Implement mechanisms for supporting cultural competency and continuous quality improvement focused on reducing disparities in care</p>	<p>Advocate for development and adoption of tools to support cost-effective care and judicious use of health care resources</p> <p>Promote public health and advocate on behalf of societal interests with respect to health and health care, without concern for the self-interest of the individual physician or the profession</p> <p>Advocate for payment policies that drive a focus on total cost of care rather than discrete encounters and individual clinician inputs</p> <p>Support development of tools to facilitate reflection on disparities in care and drive down unwarranted variation in quality and resource use</p>

<sup>2</sup> Ibid