


the other side of complexity. What might it look like? A clear understanding of what skills the resident is expected to demonstrate and a set of assessment tools that confirm achievement of those skills are two things needed to get us to "the simplicity on the other side of complexity." The skill sets are broad and will require representative rather than comprehensive testing. Combining different assessment approaches can compensate for the deficiencies of any single modality. Multiple observations over time can illuminate growth or lack thereof in skill sets. Assessment approaches that are feasible, and are woven into the experiential learning get closer to an assessment of actual performance. A range of assessment tools can be found on the ACGME web site (www.acgme.org).

Residency Review Committees (RRCs) are presently forming their initial response to this accreditation initiative. Gail McGuiness, MD, chair of the RRC for Pediatrics, chairs a "Think Tank" of RRC members from several disciplines. The group is using the nine months remaining between now and the "implementation date" of July 2002 to clarify expectations for the RRCs themselves and for accredited programs. The group's report will illuminate the work of the various RRCs. A relational database will enable experiences with different assessment techniques to be analyzed, allowing simple and effective methods to be identified.

In this time of significant change in the environment for residency education, and in the accreditation process, it is important to remember that the only things real in any residency program are the people functioning within it, and the relationships they have with each other. These relationships can either inhibit or facilitate learning. Clarifying what we want residents to learn and demonstrating whether they have

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learned those things will also clarify the substance and form of medicine. To paraphrase the architect Louis Henry Sullivan: Form ever follows function, or substance. The relationship of residents, faculty and patients is at the core of the substance of education. When the accreditation process will get at the heart of that substance, we will have reached the simplicity on the other side of complexity. 

Developing Competency in Professionalism: The Potential and the Pitfalls

Mark G. Kuczewski, PhD

What is Professionalism?

Everyone currently seems to be interested in professionalism. As readers of this publication are well aware, accrediting bodies such as the ACGME require that the programs they oversee foster competency in professionalism. Furthermore, it is a topic of increasing interest in the medical and the bioethics literature. Why? Clearly there are many answers to this question but a few bear exploring.

Invoking a sense of professionalism promises to revive aspirations for physicians that have long seemed unattainable or perhaps, less attainable in recent years. As historian David Rothman notes, the focus of discussions of professionalism has increasingly become economic arrangements that might compromise the fiduciary relationship between the physician and patient⁽¹⁾. The financial incentives to reduce utilization, gifts from pharmaceutical companies, monetary rewards for recruiting patients to clinical trials, and misplaced personal investments can lead to utilization patterns that do not place the best interest of the patient paramount. Such matters clearly deserve attention. However, the word 'professionalism' also has a variety of connotations in ordinary discourse and these reverberate through many discussions of professionalism. Among the common issues associated with professionalism are:

- Medical etiquette - Problems of grooming, dress, hygiene, and punctuality;
- Interpersonal communication - Skills in conveying meaning to and gathering information from patients, members of the health care team, students, and other health care providers along the continuum of care;

- ❑ Medical ethics - a. Issues related to the character of the physician (honesty, does not mistreat, abuse, or sexually harass students, residents, or nurses, does not engage in sexual relations with patients) b. Skills related to treatment decision making such as procuring informed consent, assessing patient decision-making capacity, and end-of-life decision making and care for patients;
- ❑ Cultural competence and sensitivity;
- ❑ Service to society - Civic leadership related to health issues, service to the underserved, the uninsured and the poor.

What can it mean that such diverse meanings are united under one banner of "professionalism?" Should we try to make sense of such a many faceted term or is it likely to be vacuous because it is so all encompassing? I believe that the professionalism movement presents a tremendous opportunity and is worth the effort to ferret out the core meaning that provides this movement its impetus. Virtually all philosophies of medicine give primacy to the physician-patient relationship.⁽²⁾ Clearly medicine exists to serve patients. This occurs because illness renders a patient vulnerable and in need of the technical expertise of the physician, an expertise that the patient is poorly situated to evaluate, the patient needs to be able to trust the medical professional. Fostering this "fiduciary" relationship (from "fides," the Latin word for "trust") traditionally formed the focal meaning of professionalism and led to an emphasis on technical competence. However, the turn toward financial relationships as well as the multifarious connotations we have highlighted reflects the evolution of the physician-patient relationship.

The duty to foster the patient's well-being remains paramount. However, the physician-patient encounter now takes place within a web of interlocking relationships involving other health care professionals, third-party payers, and a society that seeks leadership concerning the integrity of these relationships. Training physicians to be professional means teaching them to navigate this complex terrain in a

way that continues to serve the patient's best interest. We might best think of *medical professionalism as the norms of the relationships in which physicians engage in the care of patients.*

This definition in terms of relationships sheds light on the interrelationships among the competencies. Most immediately associated with professionalism proper are those norms that are closest to direct patient care such as those related to truth telling and informed consent. Of course, the implementation of these norms will draw upon communication skills and require knowledge of, and an ability to successfully navigate, the systems in which this encounter takes place. Because education must always proceed in stages, it is useful to have the competencies subdivided as has been done in the ACGME list. But, it is important in designing professionalism programs to be sure that training is directed at all the relationships that contribute to patient care and to appreciate them as integral to professionalism.

The Promise of a Focus on Professionalism

At Loyola University Medical Center, we see great promise in the new focus on professionalism. Loyola University

Chicago is a Jesuit, Catholic university. Deep within this heritage is a tradition of educating persons to serve others and promote justice.⁽³⁾

This tradition can easily be adapted to the language of professionalism in medicine. And, it is likely that such language might be far more efficacious than the traditional language of duty and ethics.

Ethics has long been a suspect term in medicine

as it suggests outsiders invading the domain of the physician to "police" clinical practice. But, emphasizing the leadership role of the physician in serving the interests of the patient and the health needs of society clearly have the ring of being endogenous to good doctoring. As a result, professionalism provides us with a vocabulary to call physicians back to their vocation. This notion of re-appropriating endogenous elements of medical tradition and medical practice has guided our efforts.

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Although we have a variety of initiatives under way to develop competency in professionalism among our residents and medical students, I will highlight just one. We have recently embarked on a focus group project with our residents to determine "best practices" related to professionalism and to use their credibility to educate our medical students in these practices. Our first forays into this area involve discussion of cases in which residents disagreed with a treatment plan or some behavior of a physician. We gathered several residents and presented them with an initial case scenario in which an attending physician complied with the request of a patient's adult daughter to withhold prognostic information from the patient.

We created a videotape of the residents' reactions to the scenario and showed this video to our third-year medical students as part of their education in professionalism. The residents' discussion served a variety of purposes: (1) identifying approaches to discussing the case with the attending physician; (2) verifying that this kind of case scenario was commonplace and that such a difference of opinion could be effectively addressed by the resident; (3) identifying the assistance of other members of the health care team, e.g., social work staff, who could be of help; and (4) demonstrating a commitment to reason through the scenario to secure a resolution that fostered the patient's good.

We believe that we will learn much from this initial group and the ones that follow it as residents "in the trenches" probably know a good deal about strategies for resolution and have a high degree of credibility with our medical students owing to the intimate role-modeling relationship of residents to medical students in the clinical years. Furthermore, asking our residents to reflect on their best practices may be an effective way to foster their own professional competence and to elicit their commitment to such practices.⁽⁴⁾ We believe this kind of reflection and role modeling must permeate our professionalism education efforts.

The Peril of the Path of Least Resistance

Any good thing can go wrong. It's not hard to see how this can happen with the attention given professionalism as a competency. Here are some obvious (and, perhaps, not so obvious) possibilities:

- ❑ Professionalism might become operatively associated with etiquette and discipline issues.
- ❑ Medical schools and residency programs may create effective disciplinary channels to deal with the unprofessional behavior of students and residents but fail adequately to address student mistreatment and related unprofessional behaviors of faculty.
- ❑ We could fail to connect professionalism with systems-based practice issues and thereby, turn professionalism in on itself rather than outward toward the role of the physician as civic leader.

All accreditation standards go through periods in which they are new, and the opportunities they provide for innovation and restructuring generate excitement, or anxiety, as the case may be. But, the ultimate measure of such standards is how they are institutionalized and implemented on an ongoing basis. Many factors help to determine this legacy including power relationships within organizations.

Although the professionalism of medical students and residents is more likely to be shaped by the behavior of their role models than any other single factor, it is probably the hardest factor to address. The behavior of faculty physicians in terms of student mistreatment including sexual harassment and failure to work effectively as part of a health care team are difficult behaviors to change and are not easily addressed given the realities of academic medicine in which faculty who are productive researchers and generate significant practice revenue must be prized. At the same time, there are no barriers to medical school or residency faculty using professionalism as a catch-all to penalize their students and residents for virtually any annoying behavior.

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This can easily create a situation that compounds the cynicism of future physicians.

Similarly, professionalism must not be a term that enables a turn inward on the profession of medicine. As the norms of the physician's relationships, it is an invitation to look outward toward those relationships and to foster the patient's good through them. This approach must extend through the interpersonal realms into systems-based practice so that the physician can serve the patient and the public at all levels. This reconnection with leadership is, perhaps, the antidote to a view of professionalism as one more way to levy external demands on the physician. It may be the way to prevent "professionalism" from going the way of "ethics."⁽⁵⁾

(1) David J. Rothman. Medical professionalism -- focusing on the real issues. *New England Journal of Medicine* 342(17): 1284-1286, 2000.

(2) Edmund D. Pellegrino, David C. Thomasma, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions*. New York: Oxford University Press, 1981.

(3) Peter-Hans Kolvenbach. True Solidarity: The Service of Faith and the Promotion of Justice in American Jesuit Higher Education. *America*, 184(3): 7-12, 2001.

(4) Jennifer Giaquinto Shreves and Alvin H. Moss. Residents Ethical Disagreements with Attending Physicians: An Unrecognized Problem. *Academic Medicine* 71(10): 1103-1105, 1996.

(5) Myles N. Sheehan. Why doctors hate medical ethics. *Cambridge Quarterly of Healthcare Ethics* 3(2): 289-295, 1994

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The ACGME's General Competency and Outcome Assessment Project: Countdown to Implementation

Susan Swing, PhD

In less than nine months, the ACGME and RRCs will begin reviewing program information for evidence that implementation of the general competencies is occurring. From July 2002 through June 2006, one major task for programs is to make sure they provide an educational environment and teaching-learning experiences that foster residents' development in all six general competency domains. Programs also will need to use methods that provide accurate, objective evidence when assessing resident performance. The identification of learning objectives for the competencies is a prerequisite of both these tasks. Not all implementation tasks must be accomplished at once, but steady progress is expected.

Currently, the ACGME is working to better define implementation expectations. One part of this work is to define a "good enough" assessment system, or in other words a set of methods that will produce sound evidence of residents' attainment of the competencies. This model system is intended to guide implementation, not prescribe exactly what programs should do. One group involved in this work is the RRC Outcome Project Think Tank, chaired by Dr. Gail McGuinness and composed of current and former RRC or ACGME members from nine specialties. This Think Tank also will participate in work to identify interim benchmarks that the RRCs and programs themselves can use to gauge adequacy of implementation progress. The goal is to complete this work by July 2002.

An efficient path to improving teaching and assessment of the competencies will involve taking advantage of opportunities to learn and apply existing ideas. The ACGME is pleased to announce the recent expansion of our General Competency and Outcome Assessment website to include, among other things, example assessment methods for two competencies. The posting of assessments for the other competencies will follow at later dates. Another new addition to the web site, named "Reports from the Field," will feature short descriptions of activities that programs are engaged in to facilitate teaching and learning of the competencies.