Core Curriculum and Core Concepts in Medical Professionalism for Students, Residents and Faculty Development

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IN THE Accreditation Council for Graduate Medical Education Outcomes and Milestones Project 2013, professionalism is one of the competencies to be observed and judged by the faculty in the current competency-based residency medical education system.

Residents are expected to demonstrate a responsiveness to the needs of patients and society above their self-interest (manage conflicts of interest and the virtue of altruism); and the ethical concepts of respect, confidentiality, informed consent, and virtues of compassion and integrity. In addition, they should demonstrate commitment to competence and lifelong learning, and show skills in cultural competence. The faculty are to teach, directly and critically observe, and judge the trainees' performance in actual patient care situations.

There is substantial evidence which suggests that the current faculty are insufficiently prepared for this task across all the competencies, including professionalism.[1] With emphasis on the formative nature of this assessment, the faculty needs to have self-efficacy in knowledge, skills and attributes relevant to the competency that is being assessed. It has been emphasised that it is the user of the tools of assessment, and not just the tools that determine the validity of the assessment.

Medical professionalism encompasses a set of duties, competencies, values (principles), virtues, behaviour (conduct), outcomes (performance) and relationships that aim to achieve the goals of Medicine, and promote trust and confidence in the healthcare system. The goals of Medicine have been traditionally described as focusing on the relief of pain and suffering, the cure of illness, the promotion of health and the improvement of quality of life.[2] In clinical Medicine, the goals have been described as the delivery of safe, effective, timely, efficient and equitable patient-centred healthcare. Medical education and research are considered secondary goals.

Medical professionalism describes the philosophy of Medicine and is a functional ideology. It also describes a multidimensional and dynamic competency with a clear knowledge and skills base. Professionalism inevitably interlaces with all the other five competencies of the residency programme.

This paper attempts to distil the core concepts in medical professionalism so as to define the core curriculum, knowledge and skills for students, residents and faculty with regard to the competency of professionalism. The core concepts of medical professionalism are:

- The doctor-patient relationship
- Consent
- Confidentiality and privacy
- Conflicts of interest
- Collegiality
- Professional governance and assessment

The doctor-patient relationship

The doctor-patient relationship is at the very sanctum of professionalism, marked by the imbalance of power, knowledge and experience. It thus has to be based on trust and should be fiduciary in nature.

The relationship is based on the fundamental value or principle of respect for persons – namely respect for their wishes (autonomy), respect for their welfare (beneficence), and a position of non-discrimination (justice), on top of appropriate sensitivity and responsiveness to patients' culture, race, religion, gender, socio-economic status, disabilities and other affiliations.

The legal principles that govern the doctor-patient relationship are the legal duty of care and the professional standards of care. Doctors must at all times work within their competence and keep up to date with their skills and knowledge. The basic ethical principle that governs the doctor-patient relationship is respect for persons and acting in the best interests of the patients.

The doctor-patient relationship is defined by professional boundaries which need to be preserved. Breaching boundaries would risk loss of objectivity of clinical and ethical judgement that would result in compromised quality of care and loss of trust. The principle of fidelity (or non-abandonment) requires doctors to act in good faith at all times. It delineates the appropriate standards in transfer of care. The virtue of altruism and fidelity mark the doctors' commitment to provide care beyond the contractual model, with acceptance of reasonable risk and inconveniences to them.

The principle of veracity requires a high level of integrity and definite avoidance of misrepresentation, collusion with patients or their families against the system, and deception of any nature.

Consent

Consent is a legal and ethical requirement before any medical intervention. In medical practice, consent is based on respect for patients' autonomy and welfare, and underlines the consensual nature of Medicine. There is no place for any form of coercion, unless it serves the patients' best interests or the public's greater good.

Consent is necessary as competent patients have the right to refuse any medical treatment even that of beneficial therapy, the refusal of which may lead to deterioration of health to the extent of death itself.

The three major elements of consent are capacity, disclosure and voluntariness, which are important to understand in order to establish effective shared medical decision making. The process of consent is an active communicative process, an educational activity, and one that builds trust and mutual respect.

Confidentiality and privacy

Medical confidentiality, which describes informational privacy, is necessary to establish trust and confidence in clinicians and the healthcare system. Clinicians need to be aware that there are legal and ethical criteria that allow for breach of confidentiality. Other forms of privacy include decisional privacy (choices), physical privacy (space), and proprietary privacy (property interests), which need to be upheld as well.

Conflicts of interest

A conflict of interest is a set of circumstances that create a risk that professional judgements or actions regarding a primary interest will be unduly influenced by a secondary interest.[3] The ethical basis of this obligation in Medicine lies in the principle of primacy of patient welfare – the fundamental obligation of doctors as healers is to serve the best interests of patients above the clinician's self-interest or that of any other third party. In a therapeutic relationship, the primary interest of the doctor is in the patient's best interest, and all other interests are secondary interests.

Conflicts of interest are problematic because they risk the patients' best interests being sidelined by a secondary interest, the integrity of medical judgement being violated and clinical outcomes being compromised. Conflicts of interest are widespread in Medicine as doctors have a primary duty of care and many secondary interests depending on their roles as healers, educators, researchers or clinic managers. Doctors have a professional obligation in responsibly managing conflicts of interest as individuals and as a profession.

Collegiality

Collegiality is a special form of relationship within professionalism, characterised by working towards a common purpose of the delivery of safe, effective, efficient and appropriate healthcare and advocacy for patients. Healthy collegiality is marked by a commitment to professional and ethical principles, and promotion of professional standards. Collegiality embodies the values of building mutual respect and trust, teamwork, in the spirit of collaboration and cooperation. It is an individual and professional commitment to patient safety, quality improvement, and advancement of medical education and research.

Professional governance and assessment

Professional governance refers to the systemic assurance of professional competency in medical education and clinical training; the acquisition of clinical and ethical competency at each stage of professional development; the promotion of professional culture at the workplace (organisational professionalism); the monitoring of professional outcomes and performance; and an appropriate system of professional accountability.

Challenges and lapses in professionalism occur daily in clinical practice, often called the hidden curriculum or survival shortcuts. Residents and students are not prepared for how to deal with observed professional lapses in faculty

and other residents. The faculty may feel powerless, and are not equipped to deal effectively with professional lapses and misconduct in residents, students and other faculty members.[4]

Professional misconduct, the abuse of professional privileges and neglect of professional duties, very much akin to medical errors, have roots as much in the healthcare system as in the competence, attitude and commitment of individual doctors. Like medical errors, lapses in professional conduct are common, inevitable but sometimes preventable.[5] Thus, they should be subjected to root cause analysis for effective remediation.

Managing the faculty's lapses and misconduct in professionalism requires skills in ethical reasoning and judgement, coaching, and an institutional culture of professionalism. Tools and skills in self-awareness, emotional intelligence, metacognition and reflection are needed to effectively learn from these lapses. In the face of complex professional challenges, residents need skills in resilience and self-confidence; coached in skills in situational judgement; counselled for moral distress; and mentored for professional development.[6] Ignoring lapses of professionalism in a residency programme is guaranteed to subvert professionalism by an insidious shift of values, attitudes and practice.

Faculty development in professionalism

The faculty need to undergo deliberate practice in assessing competency in professionalism, by equipping themselves with a sound understanding of the core concepts in professionalism that underlines the demonstration of professional behaviour. In teaching professionalism, the challenge is to integrate the learning into daily clinical practice. Large group didactic teaching of professionalism in the classroom is easy but not effective. Small group teaching and contextual learning by the bedside and in the clinic to model, reflect and demonstrate clinical and ethical reasoning makes it relevant for the students, but is challenging for the faculty.[4]

Expert professional judgement is necessary for the faculty, not only to detect lapses in professional behaviour among residents, but also hone the skills to be able to teach in a formative assessment system by explaining why the behaviour is inappropriate. This is to be followed by coaching residents in skills needed for good professional behaviour.

The faculty need to undergo a deliberative longitudinal programme to be competent in teaching, role-modelling and coaching in professionalism. Acquiring the skills and demonstrating professionalism is achieved by an incremental faculty development in a transformative learning journey, shaped over a lifetime career as the faculty.

Conclusion

Many clinicians with no formal training as educators have functioned as medical teachers for far too long. Medical teachers, who were not explicitly taught according to these competencies during their own training, now have to learn to teach these to

their learners.[7] With competency-based outcomes and milestones in medical education, medical teachers need to be explicitly trained in the knowledge base, teaching skills and role-modelling in the core clinical competencies. This is especially true for professionalism, a competency not addressed in the faculty's own medical training. *Professionalism is a multidimensional competency comprising knowledge and skills together with attributes of professional virtue and attitudes, which can be learnt, taught and role-modelled.*

Transforming a medical education system for the better is a complex adaptive challenge that needs knowledge, time and a concerted longitudinal effort by all stakeholders. The medical profession, as a whole, has to collaborate to contribute to this transformation to competency-based medical education. SMA

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