TEACHING AND LEARNING ABOUT MEDICAL PROFESSIONALISM IN A COMPETENCY-BASED MEDICAL EDUCATION

– GOING BEYOND THE CURRICULUM

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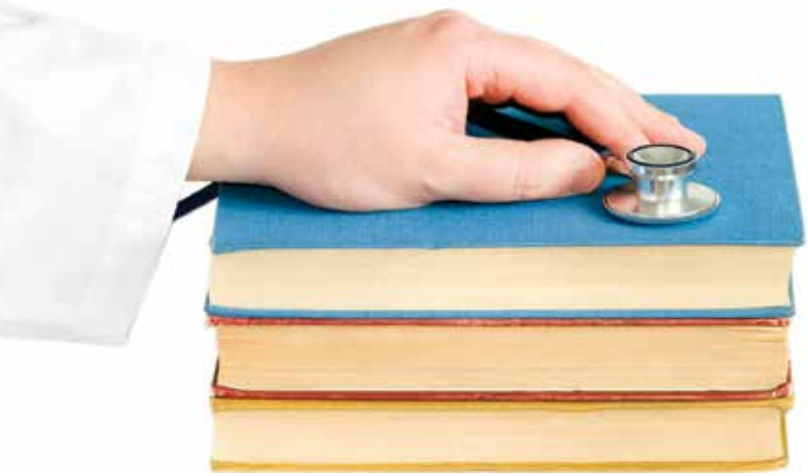

The following article is based on the Dr MK Rajakumar Memorial Oration of the same title that Dr Thirumoorthy delivered at the 16th MASEAN Conference opening ceremony on 9 May 2014.

"MEDICAL SCHOOLS with overloaded technical curricula can find little time for ethics. *All sorts of medical schools produce all types of graduates and sometimes they are ethically blind*, aware only of the status of the physician and not of the weight of moral responsibility that comes with it. Each year when I lecture to students on ethics, I commence with the complaint that *ethics should not be taught in this way but in relation to their patient by every single teacher in the faculty*. I find these *young people extremely concerned about ethical issues and more than a little confused with the reality* that they are already beginning to comprehend (italics added). There is a conflict in their value system."[1]

This was what prominent Malaysian GP Dr MK Rajakumar said when he delivered the SMA Lecture 1983: Ethical Consequences of Technological Changes. (Dr Rajakumar was the founding Chairman of MASEAN.) Although his words were uttered in April 1983, they still ring true more than 30 years later.

Therefore, it is clear that teaching and learning about medical professionalism in a competency-based medical education continues to be highly relevant and challenging. This article aims to explore this topic with regard to issues beyond the medical school curriculum. It has been grounded in my work in teaching and learning professionalism at the SMA Centre for Medical Ethics & Professionalism, Duke-NUS Graduate Medical School (Practice Course Years 1 and 2), the Medical Protection Society's risk management seminars, and the SingHealth residency programme.

Traditional teaching approach in medical professionalism

The traditional teaching approach in medical professionalism is didactic. Rules and values – musts or must nots and should or should nots – are repeatedly exhorted. Professional values and virtues are also promulgated through rituals of pledging honour codes, holding white coat ceremonies and lectures named after past role models. Those who exhibit good behaviour are recognised and rewarded, while those who falter are named, blamed, shamed and punished. "Education by humiliation" has long been a tradition in medical education, and still persists today.[2]

The role of professionalism in medical practice

Principle of primacy of patient welfare

This principle is based on dedication to serving the best interest of the patient. In addition to competence, altruism is critical to developing the trust that is central to the doctor-patient relationship. Physician self-interest, market forces, societal pressures, and administrative exigencies must not compromise this principle. Professionalism in Medicine requires the physician to serve the interests of the patient above those of his own. Professionalism also aspires towards cultivating altruism, accountability, excellence, duty, service, honour, integrity, and respect for others within the medical fraternity.[3] The application of this fundamental principle is pivotal in establishing trust in the profession, which is essential for good relationships and clinical outcomes.

Professionalism is counter-instinctive behaviour

Placing another person's interests above one's own is counter-instinctive. Demonstrating the values and behaviours of professionalism is thus counter-instinctive for most of us. Thus, it is difficult for people to exhibit a calm and professional demeanour in intense emotional situations. For example, it is clearly counter-instinctive for a doctor to show compassion and empathy when handling an aggressive patient who consistently fails to take his medication and help himself, especially when the clinician is deprived of sleep and food.

What constitutes instinctive behaviour then? Instinctive behaviour is self-interest and self-preservation. Humans are hardwired to exhibit a fight, fright and flight response in stressful situations. Therefore, when we are challenged or unexpected adverse outcomes arise, it is common to observe denial, discounting, distancing and defensive behaviours as these are our natural instinctive defence mechanisms. It is easy to understand why doctors and other healthcare professionals have difficulties reporting their own errors or those of others.

Transformative learning

In order to gain the ability to demonstrate professional behaviour in the face of challenging situations, one needs to undergo a transformative learning process to arrive at rational and intuitive wisdom, and disciplined conduct and habits. Transformative learning is a multistage and multi-step cognitive, emotional and intuitive learning process that encompasses various aspects, including:

- Psychological: exercising self-awareness, situational awareness, self-examination of beliefs and assumptions, and critical reflection of experience and oneself
- Convictional: creating paradigm shifts of personal beliefs and values
- Behavioural: consciously changing behaviour and forming new habits

Becoming a medical professional is a transformative learning journey of incremental development that is shaped over a lifetime career. It is modelled and remodelled by knowledge, experience, deep reflection, redefining beliefs, refining skills, and mentorship. As the process is counter-instinctive, experience and time are needed for internalising and imbibing the necessary values.

Faculty development is key

The key to ensuring effective teaching and learning of medical professionalism lies in faculty development. Existing training models are inadequate to prepare a physician workforce to meet the needs of an increasingly diverse and ageing population, and current faculty are insufficiently prepared for this task across both the traditional competencies of medical knowledge, clinical skills, professionalism and other newer competencies.[4]

These faculty members need to undergo a deliberative longitudinal training programme to become competent in teaching, role modelling, mentoring and coaching in professionalism. Such training is based not only on content and method, but also on experiential learning of skills, effective feedback, deep personal reflection, and supportive group processes.[5]

Developing a learning community

We need to nurture a community of self-motivated and collaborative lifelong learners to promote professionalism. Successful faculty development should result in the integration of professionalism into daily clinical practice and teaching. Medical educators have discovered the gap between how professionalism is currently instructed and how it should be taught. They know that large group didactic teaching in the classroom is easy but not ideal. Small group teaching and contextual learning by the bedside and in the clinic, which allows relevant modelling, reflecting, clinical and ethical reasoning, is essential but difficult to implement.[6]

Appreciating the role of institutional and professional culture

Even with the altruistic motives and noble mission statements of Academic Medicine, many faculty members feel that the present culture in medical schools is lonely, unwelcoming of differences, and more competitive and critical than collaborative or supportive.[7] Overall, there is a lack of diversity at all levels of leadership in medical schools. Therefore, the institutional culture in Academic Medicine contributes to high rates of faculty dissatisfaction, burnout and depression, which in turn lead to high levels of turnover and attrition.

In a 2012 study that examined why faculty consider leaving Academic Medicine, Pololi et al found that the reasons included unrelatedness, moral distress at work, lack of engagement, perceptions of values incongruence, low institutional support, and low self-efficacy.[8]

Moral distress in healthcare professionals is a prevalent and particularly concerning issue. It is defined as negative feelings that arise despite knowledge of the ethically correct response, but they are unable to or decline to act because of: constraints of hierarchies, team dynamics, and institutional culture or policy. If there is no proper closure for healthcare professionals suffering from moral distress, it could lead to moral erosion, maladaptation or loss of empathy.[9]

Burnout has been noted to affect professionalism in medical students and trainees. In a survey of 2,682 students in seven US medical schools, 53% of respondents said that they experienced burnout. Burnout was associated with self-reported unprofessional conduct and less altruistic professional values among the respondents.[10]

Challenges and lapses in professionalism

Challenges and lapses in professionalism occur daily in clinical practice, but faculty members and students are unprepared to deal with observed lapses in their colleagues and peers.[11]

Such lapses in professionalism, like medical errors, are systems issues as much as personal professional issues. Systems inadvertently create situations for lapses and misconduct to occur. Institutional policies and practices implemented must also follow professional principles, values and standards.

Faculty must be enabled to facilitate learning professional behaviour in a safe environment for timely remediation. Motivating and training a diverse group of teaching faculty and institutional leaders can build a community of trust. They can learn the attitudes, skills and behaviours to help improve the culture of academic Medicine. Participating in a trustworthy learning community can deepen understanding and cultivate effective professional performance.

Learner-centred training in professionalism

Students and trainees need a safe environment for self-awareness and transformation. Naming, blaming, shaming, ridiculing or intimidating are futile and unconstructive behaviours. The fear of negative evaluation scores and punishment, though necessary, cannot be the main driver of professional growth. On the contrary, a system that encourages feedback, provides coaching, teaches new skills and allows remediation is needed for an effective learning culture. To this end, what is required is commitment to resources and time for faculty development; commitment to physician health across the spectrum – from medical students to trainee doctors and up to the faculty at personal and organisational levels; and development of student and physician resilience skills and strategies for a lifetime career.[12]

All medical students and trainee doctors need:

- Coaching in professional skills and performance – with faculty as coaches;
- Counselling for moral and emotional distress – with faculty as counsellors; and
- Mentorship for a lifelong transformative journey of incremental professional development – with faculty as mentors. ■

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