TEACHING AND LEARNING ETHICS

Reflective professionalism: interpreting CanMEDS' ''professionalism''

M A Verkerk, M J de Bree, M J E Mourits

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Residency training in the Netherlands is to be restructured over the coming years. To this end a general competence profile for medical specialists has been introduced. This profile is nearly the same as the Canadian CanMEDS 2000 model, which describes seven general areas of medical specialist competence, one of which is professionalism. In order to establish a training programme for residents and their instructors based on this competence, it is necessary to develop a vision that does justice to everyday medical practice. The two most prevailing views of professionalism—as personal, or as a behavioural characteristic—fall short of this. Only when professionalism is understood as reflective professionalism does it encompass the fundamental contextuality of medical treatment. This means that the focus of training and assessment must be shifted to accountability for treatment.

Residency training in the Netherlands is to be restructured over the coming years. To this end a general competence profile for medical specialists has been introduced. This profile is virtually identical to the Canadian CanMEDS 2000 model, which describes seven general areas of medical specialist competence: medical expert, communicator, collaborator, manager, health advocate, scholar and professional.

Translating these core competences into a programme of study is by no means simple, however, and this is especially true of professionalism. CanMEDS describes professionalism as composed of three core competences: a physician must be able to (1) deliver highest quality care with integrity, honesty and compassion, (2) exhibit appropriate personal and interpersonal professional behaviours and (3) practise medicine ethically consistent with the obligations of a physician.[i]

CanMEDS otherwise provides very little by way of describing how professionalism can be sensibly and effectively integrated into a training programme. It is therefore necessary to develop a coherent vision of professionalism that can serve as the basis for the development of training and assessment programmes for residents.

In this paper we present just such a vision, as well as the practical implications for a training programme. (See box 2 for earlier papers in which we developed our conception of reflective professionalism.)

Here we present professionalism as a complex practice, in which accountability is the most important core competence (see, for example, Emanuel and Emanuel, 1996[1] and Oorschot *et al*, 1995).[2] We set forth why we believe professionalism must be conceived as a *second-order competence*—a reflective and evaluative competence which, analogous to Harry Frankfurt's second-order volitions[3], can be expressed only via the performance of other competences.[ii] It will become clear that our vision presupposes a tight relationship between professionalism and medical ethics, putting medical ethics right in the centre of professionalism education. We conclude with an overview of some consequences for training and assessment, based on our experiences with a pilot training programme we designed for obstetrics and gynaecology residents and their instructors. In this regard we focus primarily on training in and assessment of what we call the *deliberative and moral components of professionalism*. We begin, however, with a short discussion on some prevailing ideas of professionalism.

CURRENT VIEWS OF PROFESSIONALISM

The literature offers two principal ways of viewing professionalism: as a *personal* or as a *behavioural* characteristic. (For further reading, see box 2.)

When professionalism is considered as a *personal* characteristic, the focus is on personality formation, in which case resident training is a matter of ''the right person doing it''.[6] This presupposes that a good character or personality is a dominant factor in determining behaviour: physicians who *are* professional will automatically *behave* professionally. Residents are professionals when they are empathic and conscientious, for example, and demonstrate this in their treatment of patients. CanMEDS itself also mentions personal characteristics such as altruism and honesty.

But because personality is not directly discernible (which makes training and assessment more difficult), professionalism is often interpreted as a quality of *behaviour*. Behaviour is seen as the

See end of article for authors' affiliations

Correspondence to: Professor M A Verkerk, University Medical Center Groningen, University of Groningen, Expertisecenter for Ethics and Care, PO Box 196, 9700 AD Groningen, The Netherlands; m.a.verkerk@med.umcg.nl

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[i] The CanMEDS roles were updated in 2005 and the definitions of all roles and underlying competences were partly altered. These changes, however, do not influence our stand towards professionalism as a competence, as elaborated in this article.

[ii] Harden and colleagues[4 5] use the term ''meta-competence'' to refer to a competence that can be expressed only via the performance of other competences. However, we prefer the term ''second-order competence'' in relation to professionalism, in order to underline its reflective and critical character.

external manifestation of the professional's (inner) personality. According to this interpretation, people are professionals if their behaviour satisfies prescribed criteria. This seems to be the predominant view on creating and assessing medical professionalism in the Netherlands. For this purpose, professional behaviour is seen as having three dimensions: dealing with one's tasks, with others and with oneself.[7]

OBJECTIONS

Both visions must contend with important objections, however. One of these is that neither view does justice to the *contextual dependence* of professionalism. This has important implications. We can see this, for example, in the situation of assessment. Both visions are inherently normative: what a good personality is (or what it means to behave well) is presumed to be known and self-explanatory. Alas, this is not so; after all, assessment criteria are determined by instructors subject to social and cultural as well as professional diversity.[8] And who determines the measure for sincerity or concern by which residents are assessed? Ginsburg *et al*[9] are sceptical about the idea that an objective appraisal of professionalism can be made by means of perception of behaviour. They suggest that instructors see different things and use different measures.

Second, research has revealed that the environment in which residents work greatly influences individual behaviour. If one focuses exclusively on the *individual* professional behaviour or personality of residents, professional practice remains unexamined. This is problematic, given the socialising effects of environment in general. Frequently, residents are socialised as *medical technicians*; they are taught that professional behaviour requires clinical distance.[10] After all, accurate observation and decision-making require objectivity. Residents work in a technical field of medicine, and that is where their expertise lies. While concern for patients is important, it must nonetheless be handled with clinical distance: the thinking is that doctors must treat patients first; if patients need to talk, then they must do so with someone else. As long as residents continue to be trained in unreflective environments like this, they will quickly adapt themselves to the mores of their teachers. Any and all subsequent professional training runs the risk of being seen as obligatory and irrelevant. It is therefore also important for the acquisition of professional behaviour to examine the environment, and in particular the culture in which behaviour is taught. (See box 2 for further general reading on professionalism.)

In addition to this problem of *relative normativity*, context is important for a third reason. Neither view of professionalism just described takes into account how those within the occupation understand professionalism. For example, take a situation in which a physician does not tell a patient the truth. If professionalism is seen as a characteristic of behaviour or personality, then this must be judged unprofessional, either because the resident is lacking an important personality characteristic (''honesty''), or because the behaviour fails to meet professional norms (''one must always speak the truth'').

There are, of course, situations in which for the patient's benefit it is in fact professional behaviour for a physician not to tell the truth, or to tell a white lie. Were doctors to give patients frank and very bad prognoses for which the patients were in no way prepared, we could indeed question their professionalism. The two prevailing viewpoints on professionalism do not, however, offer good explanations for why this is so. There is, at any rate, no room for context-dependent assessment. Insufficient attention is paid to the fact that professionalism deals with the accountability of choices and decisions made in situations where conflicting values and norms are prominent.[10] Physicians are not infrequently confronted with situations where a choice must be made between telling the truth and leaving the patient a little hope. The decision depends on the specific situation and cannot be prescribed in advance. Physicians' professionalism consists of their consciousness of such conflicts and their awareness that they must be able to justify their decisions to others.

REFLECTIVE PROFESSIONALISM

In short, in order to judge professionalism it is important to know *how* a professional arrives at a specific act. A professional is someone who can explain why in *this* case, for *this* patient, the professional's behaviour or decision was appropriate. Professionalism here does not mean clinging to absolute norms or values, but implies that one is prepared to be *accountable* in the light of public, professional and personal norms and values.[10] As professionals, physicians are accountable for decisions made regarding patient care within a given context and professional environment. In practice, accountability means that professionals ''can be called on to *justify* or change [their] actions'' in the fields of action for which they are legitimately responsible (Emanuel and Emanuel, 1996, p230).[1]

Accountability takes place in a complex reality in relation to *significant others*: patients, other practitioners, the healthcare organisation, professional associations, society, etc. Evidence-based work, good communication with the patient and taking the social context of patient care into account are all elements of a *normative pattern of expectations* for professional medical care. CanMEDS thus specifies that a physician is accountable *in* her role as medical expert, communicator, collaborator, manager, health advocate and scholar. For this reason, we see professionalism as a *second-order competence*; a reflective and evaluative competence that can be expressed only via the performance of other competences (see box 2).

A professional physician is someone who does the good things in the right way (see also box 2, Verkerk, 2004). Being able to justify oneself as a professional thus implies that one is capable of justifying *both* the technical dimension of one's actions and decisions *and* the normative one. The technical dimension is being addressed during ''regular'' medical training. The technical dimension of residency training often gets plenty of attention and can be fairly easily assessd. The normative dimension, however, often receives only lip service or is too crudely understood. As professionalism cannot be achieved unless the resident has learned not only technical but also normative competence, the focus of the training intended to professionalise residents must be on honing the deliberative and moral skills that allow them to be ethically accountable. Therefore, we see the normative dimension of justification as the prime focus of professionalism education. Although professionalism must be seen as a second-order competence, we want to retain the idea that normative justification can be conceived of as a separate subject of instruction and assessment.

As a consequence, the place of medical ethics in our vision of professionalism is far more central than when professionalism is seen as a quality of personality or behaviour. In the latter cases, ethics seems relevant only in the process of setting the desired standards for personality or behaviour. When professionalism is viewed in terms of accountability and normative and technical justification, compliance with external standards alone will not do. *Reflective professionals* possesses the deliberate and moral skills needed to be able to justify their actions. They know who they are, morally speaking, know the position from which they speak and provide care, are sensitive to the demands of each situation and are able to work out the right thing to do.

Box 1 Standard protocol for use by residents taking a case history in the professionalism programme

We found that the quality of case histories improves when a standardised protocol is used to generate them. We request residents to write their case histories on the spot, according to the following guidelines. The whole procedure takes approximately 20 minutes.

- Write down the case history in keywords.
- Exchange the history with a neighbour, in order to detect unclear elements in the story.
- In the writing phase, in which the case history has to be written down in full detail, also pay attention to your emotions and your interpretations of the situation you encountered, in order to avoid producing only ''technical'', objective accounts.
- Finally, answer two questions: (1) why did you submit this case (and not another)? and (2) if the case history is being used during a training session, which themes do you think should be addressed?*

*This gives us an idea of the needs for education, and an impression of the level of abstract ethical thinking.

Box 2 Further reading

Earlier works developing the conception of reflective professionalism

- Verkerk MA, Bree M de, Jaspers F. Visies op professioneel gedrag. *Med Contact* 2004;**59**:2035–7
- Verkerk MA, Bree M de, Jaspers F. Reflectieve professionaliteit. Naar een invulling van het CCMS-competentiegebied 'professionaliteit'. *Tijdschrift voor Medisch Onderwijs* 2005;**24**:162–7

Good overviews of professionalism as a personal or as a behavioural characteristic

- Arnold R. Assessing professional behaviour: yesterday, today and tomorrow. *Acad Med* 2002;**77**:502–15
- Ginsburg S, Regehr G, Hatala R, *et al*. Context, conflict, and resolution: a new conceptual framework for evaluating professionalism. *Acad Med* 2000;**75**:S6–11.

Further discussion of professionalism

- Wear D, Kuczewski, M. The professionalism movement: can we pause? *Am J Bioeth* 2004;**4**:415–523
- Verkerk MA. Ethiek en kwaliteitsbeleid. In: Slagter M, Meijering F, Jacob-Moonen I, *et al*, eds. *De gepassioneerde professional*. Assen: Van Gorcum, 2004:9–15.

CONSEQUENCES FOR TRAINING

This concept of reflective professionalism has at least three consequences for training. First, training in professionalism must be related with training in other competences. Second, training must not be seen as primarily consisting of the execution of prescribed treatments, but as a training in dealing with normative aspects of justification. Finally, training and assessment of professionalism take place in residents' everyday practice. This implies that instructors also should be trained in the field of reflection and accountability, that they are able to assess professionalism and that they have deliberately chosen this way of developing professionalism. This is important, because otherwise any initiative in professionalism training will fail in the face of instructor resistance.

Within this framework, we developed a training programme, ''reflective professionalism'', for residents and a shorter, adapted version for the faculty. We did this at the request of the Department of Obstetrics and Gynaecology of the University Medical Center Groningen. The outline and content of both programmes are briefly sketched below.

The focus of the residents' programme is on reflection and accountability. In order to be able to justify actions in moral complex cases, residents must (i) have knowledge of the most frequent moral issues in their specialty as well as the most relevant theories and views, (ii) be prepared to take and defend a stand on moral issues, (iii) be conscious of the normative backgrounds to how they act and their normative expectations, (iv) be conscious of mutual differences regarding normative expectations and backgrounds and be able to place these within a framework and (v) be prepared to contribute to professional discussions on morality.

In practice, this means that residents follow a programme of six 2-hour meetings. The first is an introduction to the concept of professionalism as an aspect of responsibility, after which residents are asked to submit a case history, using a standardised protocol (box 1). Three demands are made of these case histories: (1) they must have taken it themselves, from a patient, (2) it must deal with the question of the quality of justification (accountability) or with the tension between context and individual and (3) it must deal with a problem or doubt actually experienced by the resident.

These case histories are subsequently classified according to themes. These themes, to which are added ones taken from the relevant literature, form the subjects of subsequent meetings (table 1). By delivering a great deal of the building materials of the training programme, residents have a huge influence on the agenda of the meetings. In this way we try to avoid a gap between the training programme and everyday practice. It is also a way of generating commitment; we address only the themes and case histories that the residents have indicated are worth reflecting on.

During the meetings a short theoretical introduction is provided regarding the day's theme. We then switch to case deliberation in order to practice normative and deliberative skills. In order to achieve this, various instruments are used, such as analytic exercises, debating techniques and Socratic dialogue, and the Reflection Enhancement Tool.[11 12]

The programme for instructors consists of three 2-hour meetings. The theoretical part of the programme focuses on three topics: the concept of reflective professionalism and implications for educating residents, the assessment of professionalism, and the question of how attention to the training context (of which instructors are a part) can contribute to the professional training of residents.

Since faculty members have to assist and assess their residents, the practical part of the training consists of case discussions, in order to improve reflective competences. We use the same methods as we do with the residents. Case histories for discussion are delivered by faculty using the same protocol as with the residents. We ask for real, experienced case histories, which the faculty members think will be useful for current residents, too, to reflect on.

Table 1 Themes for residents' training programme in ethics

	Source of theme	
Area of relevance	**Literature search**	**Residents**
Patient/physician relationship	Informed consent Mature/minors Disclosure, telling the truth Boundary issues	Autonomy Disclosure Value change of patients during treatment
Mother/child relationship	Abortion Caesarean section	Abortion Caesarean section
Fertility	IVF/AID	IVF/AID
Miscellaneous	HIV/Aids Research ethics Religious and ethical values of patients Research, education and medical care	Hierarchical relations with faculty The place of own values Loyalty to the organisation Dealing with uncertainty

AID, artificial insemination by donor; IVF, in vitro fertilisation.

CONSEQUENCES FOR ASSESSMENT

The final component of residency training concerns assessment: which instruments should be used? It is, in any case, clear that one of the most frequently used methods to assess professionalism—namely, assessing observed behaviour by means of general norms or values—is not suited for our purpose. After all, assessment should be directed towards the process of normative justification, not towards judging behaviour. Another problem with sticking to assessment of observed behaviour is that this method fails to take the context into account (see Ginsburg *et al*, 2004).[9]

Presenting an alternative, however, is not so easy. There is simply a lack of a broad range of validated instruments suited for our purposes, a situation confirmed by other studies.[13–15]

While bearing in mind that matters in this field are subject to change, we have chosen to apply the following three types of instrument to assess the deliberative and normative dimensions of professionalism. First, sound argumentation and proper application of the theory in everyday practice are being assessed by written case analysis. Following a protocol, residents have to justify on paper their ''solution'' for a morally complex situation.

Second, we make use of the Reflection Enhancement Tool in order to assess the deliberative components of professionalism. This tool consists of three levels of reflection upon a case history, the upper level being the level of multidisciplinary care.[11] In a small-group exercise, we ask residents to identify themselves individually with one of the actors in a case concerning multidisciplinary care. After reflecting on their own moral stand and conflicting needs, residents are asked to negotiate with each other in order to achieve a consensus about what to do. The whole process can be documented on paper and can only be accomplished when group members master dialogical skills.

Third, we make use of portfolio assignments in order to enable residents to reflect on their own conceptions of professionalism and their own development in this field. The themes residents mentioned in the miscellaneous section are especially suited for this kind of personal reflection (see table 1). These portfolios also are very instructive for instructors, since they can use this information in order to determine how they can shape their instruction to match the needs of everyday practice (see box 1, Wear and Kuczewski, 2004).

In this light, also, a focus group as an evaluation instrument might well yield results. Such a group must then meet for some time after the end of the training. The discussions should focus on participants' experiences: how did they apply what they learned and the skills they developed, and with what results? For teachers, these sessions will provide important information about how instruction fits (or fails to fit) with practice. For residents, these meetings should serve as an exercise in self-reflection, a chance to compare experiences and a critical approach to the question of whether they have become better professionals.

Authors' affiliations

M A Verkerk, M J de Bree, University Medical Center Groningen, University of Groningen, Expertisecenter for Ethics and Care, Groningen, The Netherlands
M J E Mourits, University Medical Center Groningen, University of Groningen, Department of Obstetrics and Gynaecology, Groningen, The Netherlands

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