Education in Professionalism: Results from a Survey of Pediatric Residency Program Directors

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Abstract

Background The Accreditation Council for Graduate Medical Education (ACGME) requires pediatric residency programs to teach professionalism but does not provide concrete guidance for fulfilling these requirements. Individual programs, therefore, adopt their own methods for teaching and evaluating professionalism, and published research demonstrating how to satisfy the ACGME professionalism requirement is lacking.

Methods We surveyed pediatric residency program directors in 2008 to explore the establishment of expectations for professional conduct, the educational experiences used to foster learning in professionalism, and the evaluation of professionalism.

Results Surveys were completed by 96 of 189 program directors (51%). A majority reported that new interns attend a session during which expectations for professionalism

are conveyed, either verbally (93%) or in writing (65%). However, most program directors reported that "None or Few" of their residents engaged in multiple educational experiences that could foster learning in professionalism. Despite the identification of professionalism as a core competency, a minority (28%) of programs had a written curriculum in ethics or professionalism. When evaluating professionalism, the most frequently used assessment strategies were rated as "very useful" by only a modest proportion (26%–54%) of respondents.

Conclusions Few programs have written curricula in professionalism, and opportunities for experiential learning in professionalism may be limited. In addition, program directors express only moderate satisfaction with current strategies for evaluating professionalism that were available through 2008.

Editor's note: The online version of this article contains the survey instrument used in this study.

Background

Teaching and assessment of professionalism are required by the Accreditation Council for Graduate Medical Education (ACGME), and the medical literature both describes curricula for professionalism and suggests pedagogical approaches.[1–5] At the same time, professionalism remains a significant educational challenge,[6] and no interventions have been empirically proven to foster learning in professionalism.

The conceptual model by Stern and Papadakis[7] for teaching professionalism includes setting expectations, providing experiences, and evaluating outcomes. Although their recommendations are focused on undergraduate medical education, they can be adapted to residency training. Guided by this model, we surveyed pediatric residency program directors to explore their strategies for satisfying ACGME requirements regarding professionalism.

Methods

Study Population

We identified participants from an ACGME list of pediatric residency program directors.[8] A total of 189 participants met inclusion criteria.

Survey Instrument

Because no standard list of items about professionalism training exists, the survey included items derived from the medical literature and questions developed by 2 of the investigators (J.C.K. and T.C.S.), who are program directors or associate directors. We pilot-tested the instrument to ensure it captured the intended domains and revised it as needed to enhance clarity and ease of responding. The final 28-question survey instrument

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TABLE 1	**CHARACTERISTICS OF PROGRAM DIRECTORS AND SOURCES OF LEARNING FOR CURRICULUM DEVELOPMENT (N = 96)[a] DEMOGRAPHIC CATEGORY**	
Demographic Category	**Characteristic**	**Median Response (IQR or %)**
Program Director Experience	Number Of Years From Residency Training	18 (11–26)
	Number of Years As Program Director	5 (3–10)
Respondent Gender	Male	48 (51%)
Sources of Learning for Curriculum Development	Program Director Conferences	89 (94%)
	Reading in Medical Education Literature	68 (72%)
	Medical Education Conferences	57 (60%)
	Mentorship from Experienced Medical Educator	46 (48%)
	Reading in Ethics Literature	31 (33%)
	Formal Graduate Training In Education	10 (11%)
	Fellowship Program In Medical Education	10 (11%)
Training Sites for Residency Program	At Least One Site A Free-Standing Children's Hospital	38 (40% Responded Yes)
	At Least One Site Affiliated With A Medical School	92 (97%)

Abbreviation: IQR, interquartile range.

[a] Responses may not sum to N = 96 due to missing data.

(provided as online supplemental material) asked how program directors set expectations for professional conduct; whether the program has a written curriculum in professionalism or ethics; what the educational experiences are that are used to teach professionalism; and whether residents had the opportunity to participate in experiences that could foster learning. Participants also rated their program's success in teaching professionalism, and the survey concluded with questions on the assessment of professionalism.

Survey Process

In the fall of 2008, we sent the online survey to program directors (Illume; DatStat, Inc., Seattle, WA). After 2 e-mail reminders, nonrespondents were sent a paper copy of the survey via Federal Express. Respondents were entered into a raffle for a $200 gift certificate.

The study was approved by the Institutional Review Board at the Dana-Farber Cancer Institute, which waived the requirement for documentation of consent. Analyses were descriptive and were conducted using SAS version 9.1 (Cary, North Carolina) statistical software.

Results

Demographic Characteristics

The response rate was 51% (96/189). Respondents reported a median of 18 years since completion of their

own residency training and a median of 5 years of service as program directors (TABLE 1).

Setting Expectations for Professionalism

Seventy percent (67/96) of respondents reported that their program satisfied the ACGME requirement for teaching and assessment of professionalism. Most reported that new interns receive expectations for professionalism in writing (65% [62/96]) and verbally (93% [90/96]) (TABLE 2).

Experiences to Foster Learning in Ethics and Professionalism

Twenty-eight percent (27/96) of respondents reported that their program had a written curriculum in ethics and/or professionalism, 46% (44/96) of respondents reported that their program had an unwritten curriculum, and 26% (25/96) of respondents responded that their program had no curriculum in this area. FIGURE 1 shows the proportion of residents that participated in experiences that might foster learning in professionalism.

When assessing their own program's success in fulfilling each of the 6 ACGME core competencies (FIGURE 2), fewer than half of program directors gave ratings of "very successful" to professionalism. Similarly, a minority indicated that their programs were "very successful" in achieving Systems-based Practice and Practice-based Learning and Improvement competencies.

Expectation	Yes (%)	No (%)
TABLE 2 — SETTING EXPECTATIONS FOR PROFESSIONALISM (N = 96)[a]		
Has your residency program defined in writing "the specific knowledge, skills, and attitudes required" to demonstrate professionalism?[b]	67 (70)	24 (25)
Does your program give incoming residents written expectations for professionalism?[c]	62 (65)	29 (30)
Do new interns attend a session during which leadership verbally conveys expectations for professionalism?	90 (94)	6 (6)
Are there other ways in which your program conveys expectations for professionalism?[d]	68 (72)	27 (28)

[a] Responses may not sum to N = 96 due to missing data.
[b] Five (5%) of respondents chose "unsure" for this item.
[c] Four (4%) of respondents chose "unsure" for this item.
[d] Examples included: expectations are set during our curriculum on professionalism; expectations are set during resident retreats; individualized learning plans may include expectations for professional conduct; residency classes may create their own code of conduct to set their collective expectations for professional conduct; and setting expectations through analysis of cases/vignettes about professionalism.

Evaluation of Professionalism

Program directors were asked what strategies they used for evaluating residents' professionalism (TABLE 3). The strategies they used most frequently were those to which they assigned the highest value. Nevertheless, only 25%–53% (24–51/96) of respondents who reported using these evaluation tools rated them as "very valuable."

Discussion

Our survey found that a minority of program directors reported their program had a structured, written curriculum in ethics or professionalism. Most respondents reported that none or few of their residents participated in the majority of 14 experiences intended to foster learning in professionalism. Although respondents reported using
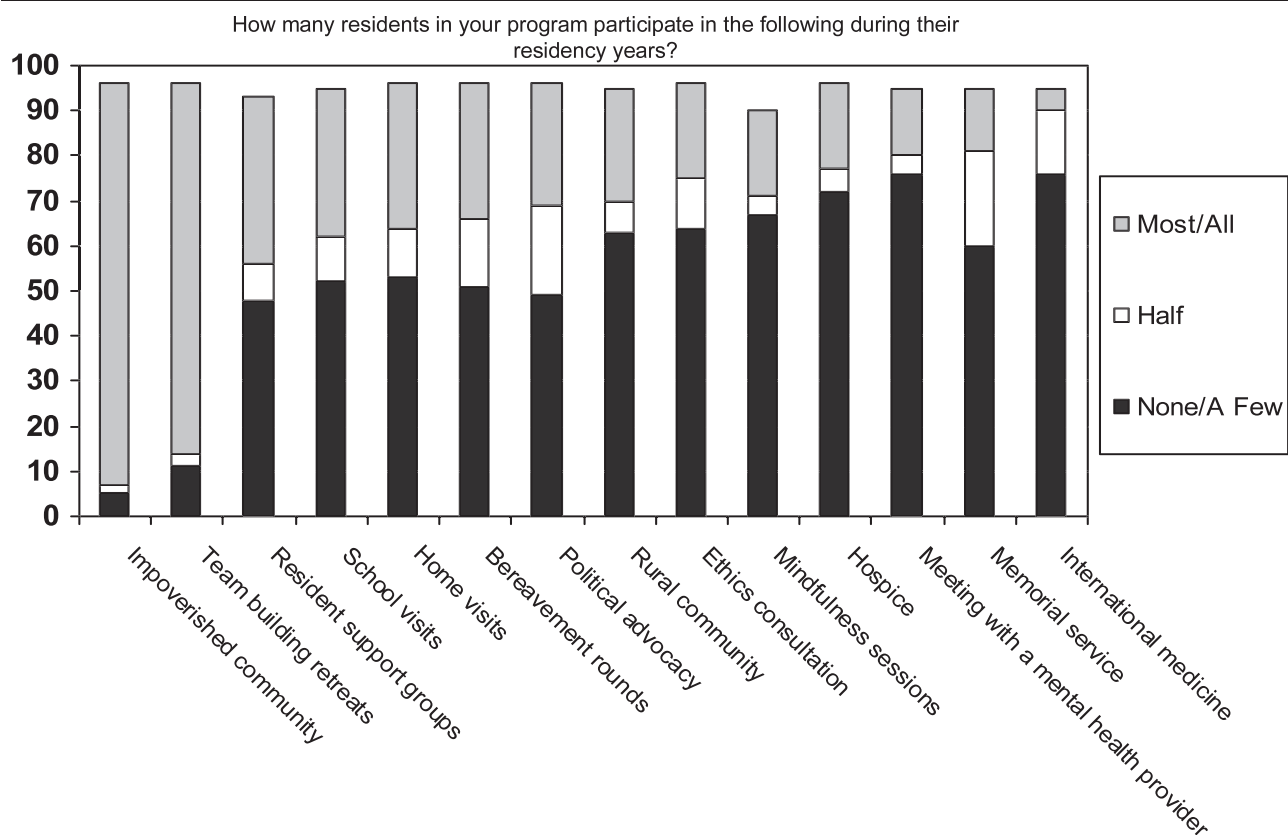

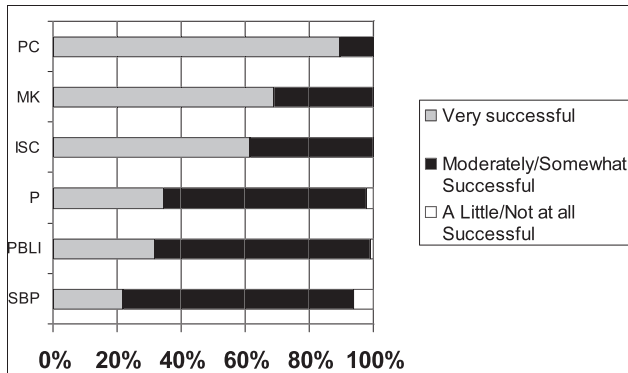FIGURE 1 — EXPERIENCES TO FOSTER ETHICS AND PROFESSIONALISM (N = 96)

FIGURE 2 | **PROGRAM DIRECTORS' RATINGS OF THEIR OWN PROGRAM'S SUCCESS AT FULFILLING ACGME COMPETENCIES**

Abbreviations: PC = Patient Care, MK = Medical Knowledge, ISC = Interpersonal Skills and Communication, P = Professionalism, PBLI = Practice-based Learning and Improvement, SBP = Systems-based Practice.

multiple methods to evaluate professionalism, they rated the value of these strategies as modest at best.

Similar to a prior study,[9] we found that many pediatric programs lack formal professionalism curricula. However, because our survey distinguished written from unwritten "curricula," our data reveal that true written curricula are even less common than previously demonstrated. Only 28% of our respondents reported having written curricula, despite accreditation requirements for

written documentation of educational experiences and plans to institute similar expectations for eligibility for graduate medical education (GME) payments.[10,11]

We applied a widely accepted conceptual model for professionalism education[7] to broadly examine the setting of expectations for professional conduct, experiences provided to foster professionalism learning, and methods to evaluate professionalism. Adult learning theory indicates that lessons should be active and relevant to the learner's world,[12–14] so experiential learning is an essential component of residency training. Program directors reported that few learners participate in experiential learning activities related to professionalism, such as visiting patients at home or in school, participating in ethics consultations or hospice care, or reflecting through memorial services or resident support groups, suggesting opportunities to expand and study experiential learning as an intervention to foster professionalism. Because effectively bolstering experiential learning to teach professionalism requires engagement and expertise of teaching faculty, our findings highlight the importance of faculty development to ensure the quality of training in this area.

Our study has several limitations. The instrument was limited by the lack of previously validated questions, methods, or measures of the elements of our conceptual model of professionalism education. To address this concern, we pilot-tested the instrument to ensure that the items measured the intended domains of professionalism training. Second, because no evidence-based list of experi-

TABLE 3	EVALUATION OF PROFESSIONALISM (N = 96)[a]	
What Strategies Does Your Program Use To Evaluate Residents' Professionalism?	**No. of Respondents Using Strategy (%)**	**No. of Respondents Who Found Strategy Very Valuable (%)[b,c]**
360-degree Global Rating Evaluation	94 (98)	51 (54)
Written Evaluation by Attendings	93 (97)	24 (26)
Patient/Parent Questionnaire	88 (92)	33 (38)
Written Evaluation by Peers	79 (82)	40 (51)
Checklist Evaluation	65 (68)	8 (12)
House Officer Written Self-Assessment	64 (67)	16 (25)
Critical Events File or Portfolio	55 (57)	24 (44)
Observed Simulated Clinical Encounter (OSCE)	28 (29)	14 (52)
Written Examinations	28 (30)	10 (36)
Standardized Oral Examination	17 (18)	6 (35)
Chart Stimulated Recall Oral Examination	16 (17)	3 (20)

[a] Responses may not sum to N = 96 due to missing data.
[b] Denominator includes respondents who report using this strategy of evaluation.
[c] Response options included "Very valuable," "Somewhat valuable," "Not valuable at all," and "Not sure/No opinion."

ences known to foster learning in professionalism is available, we compiled our own list for the survey. This list may facilitate curricular development and can guide future research about professionalism education. Third, the lack of availability of demographic data about nonresponding program directors hindered our ability to evaluate the generalizability of our findings. Fourth, in some cases, the program director may not be the individual who is the most knowledgeable about this topic within the program. In addition, programs may have updated their strategies for teaching and evaluating professionalism since the survey was conducted. Finally, the survey relies on self-reporting and is subject to bias.

Our data indicate that providing educational experiences to teach professionalism and adequately evaluating professionalism remain significant challenges in GME.

Conclusions

Our findings of a paucity of formal curricula and experiential learning to foster professionalism reinforces concerns that the teaching of professionalism is increasingly complex[6] and that medical educators feel limited in their abilities to effectively teach this content.[15] Our data show that many program directors do not consider themselves successful at fulfilling the professionalism competency.

Our study also sheds light on the evaluation of professionalism in the context of the ACGME requirement for evaluating the competencies and efforts to improve the quality of evaluations.[16] Program leaders may benefit from additional training in implementing instruments to evaluate professionalism and interpreting data derived from them. The American Board of Pediatrics has developed an instrument for the assessment of professionalism,[22] and the experience of educators in other specialties may be useful for pediatric program directors. For example, 360-degree global rating evaluations (multisource feedback) have demonstrated validity and reliability in various practice settings, indicating that they may have more potential value than our respondents perceive.[17,18] The mini-clinical evaluation exercise (mini-CEX), a direct observation technique that has been recommended by medical educators in internal medicine,[19,20] may prove valuable as well. Finally, the development of new instruments may yield additional strategies for evaluating professionalism.

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