Inconsistent role modeling of professionalism in family medicine residency

Resident perspectives from 2 Ontario sites

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Abstract

Objective To explore how family medicine (FM) residents experience role modeling of professionalism by FM preceptors.

Design Qualitative design using semistructured, one-on-one interviews.

Setting Two FM teaching units at the University of Toronto in Ontario.

Participants Sixteen first- and second-year FM residents.

Methods This study employed a qualitative description design. The CanMEDS–Family Medicine 2009 framework was used to help design interview questions. Interviews were audiorecorded and transcribed verbatim. Transcripts were coded and themes were developed.

Main findings Some residents described insufficient experience with role modeling in general. Two main findings were that a longitudinal relationship with a role model was important and that residents desired a close working relationship with a role model in a clinical setting. Most participants could identify experiences with role modeling of ethical practice; many examples were in the context of challenging patients. Some, but not all, residents could identify experiences with role modeling of profession-led regulation and reflective practice. Of note, there were mixed responses with respect to role modeling a commitment to personal health.

Conclusion Reassuringly, many FM residents described experiences with positive role modeling of professionalism. However, some residents believed that role modeling was limited by the brevity of their interactions with potential role models. To optimize the effect of role modeling, educators should support opportunities for residents to develop close, longitudinal working relationships with faculty.

Editor's key points

- Family medicine residents described experiences with positive role modeling of many aspects of professionalism, including ethical practice, profession-led regulation, and reflective practice. However, there were marked inconsistencies in resident experiences with role modeling of a commitment to personal health.
- Slightly more than half of the participants believed they had insufficient experiences with role modeling of professionalism. Analysis of these responses identified 2 main areas of concern: the importance of a longitudinal relationship with a role model, and the need for close working relationships between learners and preceptors in a clinical setting.
- Characteristics of effective role models identified by at least 2 respondents included availability, clinical excellence, empathy, explicit efforts to role model, good communication skills, interest in teaching, self-reflection, transparency, and respect for others. Respect for others was the characteristic identified the most often.

Points de repère du rédacteur

- Les résidents en médecine familiale ont décrit des expériences de modèles de rôle positifs dans de nombreux aspects du professionnalisme, notamment la pratique selon des normes éthiques, l'autoréglementation par la profession et la pratique réflexive. Par ailleurs, il y avait des incohérences marquées dans les expériences des résidents quant aux modèles à reproduire sur le plan de l'engagement envers sa propre santé.
- Un peu plus de la moitié des résidents croyaient ne pas avoir eu assez d'expériences des rôles à imiter en matière de professionnalisme. L'analyse de ces réponses a permis de dégager 2 principaux domaines de préoccupation : l'importance d'une relation longitudinale avec un modèle de rôle, et la nécessité d'étroites relations de travail entre les apprenants et les précepteurs dans le milieu clinique.
- Parmi les caractéristiques de modèles de rôles efficaces mentionnées par au moins 2 répondants figuraient la disponibilité, l'excellence clinique, l'empathie, les efforts manifestes pour être des modèles, de bonnes habiletés en communication, l'intérêt envers l'enseignement, l'autoréflexion, la transparence et le respect d'autrui. Le respect d'autrui était la caractéristique qui a été citée le plus souvent.

Incohérence dans les modèles de rôle relatifs au professionnalisme durant la résidence en médecine familiale

Points de vue des résidents de 2 unités en Ontario

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Résumé

Objectif Explorer la façon dont les résidents en médecine familiale (MF) font l'expérience des modèles de rôles en matière de professionnalisme incarnés par les précepteurs en MF.

Type d'étude Étude qualitative à l'aide d'entrevues individuelles semi-structurées.

Contexte Deux unités d'enseignement en MF à l'Université de Toronto (Ontario).

Participants Seize résidents de première et deuxième années en MF.

Procédure Cette étude était conçue sous forme de description qualitative. Le référentiel CanMEDS – Médecine familiale de 2009 a servi à élaborer les questions de l'entrevue. Les entrevues faisaient l'objet d'un enregistrement sonore et d'une transcription mot à mot. Les transcriptions étaient ensuite codées, puis les thèmes étaient dégagés.

Principales constatations Certains résidents ont décrit des expériences insuffisantes avec les modèles de rôles en général. Deux principales constatations ont été cernées : l'importance d'une relation longitudinale avec le modèle de rôle, et le désir des résidents d'avoir une relation de travail plus étroite avec le modèle dans le milieu clinique. La plupart des participants pouvaient évoquer des expériences avec des modèles à imiter pour une pratique éthique; de nombreux exemples concernaient des patients difficiles. Certains des résidents, mais pas tous, ont pu identifier des expériences de modèles de rôles relatifs à l'autoréglementation par la profession et à la pratique réflexive. Fait à souligner, les réponses n'étaient pas uniformes quant aux modèles à reproduire sur le plan de l'engagement envers sa propre santé.

Conclusion Il est rassurant de constater que de nombreux résidents en MF ont décrit des expériences positives auprès de modèles des rôles en professionnalisme. Toutefois, certains résidents croyaient que les modèles de rôles étaient limités par la brièveté des interactions avec de potentiels modèles à imiter. Pour optimiser les effets de leur rôle de modèle, les enseignants devraient favoriser des possibilités pour les résidents d'établir des relations de travail étroites et longitudinales avec les membres du corps professoral.

Although professionalism is an essential competency for physicians, it is challenging to teach.[1,2] CanMEDS–Family Medicine (CanMEDS-FM) is a framework of 7 competencies that guide family medicine (FM) curricula in Canada; professionalism is 1 of the 7 competencies. The 2009 version of CanMEDS-FM defines *professionalism* as being "committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behaviour."[3] There are 4 components to the professional role according to the CanMEDS-FM framework (**Table 1**).[3]

A systematic review identified role modeling as one of the best techniques for cultivating professionalism in learners.[4] Professional identity formation is an emerging professionalism paradigm that provides a theoretical basis for the effect of role models on learners; this framework focuses on the progressive identity development of learners through participation in a community of practice that holds to certain values and aspirations.[5]

Role models are people within the community of practice that learners wish to join.[1] *Role modeling* has been defined as the demonstration and subsequent emulation of specific professional behaviour[6] and, we would add, attitudes. There is a growing call in the literature for educators to strive toward more intentional, explicit role modeling of professionalism.[7,8]

It has been suggested that there are 3 main attributes of an effective role model: clinical competence, excellent teaching skills, and positive personal qualities.[7,9] There is evidence that many attributes associated with being an excellent role model are related to skills that can be acquired.[10] To recognize the influence of role modeling on learners, it is important for educators to learn how to be effective role models.

While there is emerging literature on how some preceptors view themselves as role models,[9] there is a lack of data from the learners' perspective on how learners perceive and respond to role modeling. To address this gap in the literature, we sought to explore the experiences of FM residents as the recipients of role modeling of professionalism. A better understanding of resident experiences will enable preceptors to serve more effectively as role models of professionalism.

Methods

We conducted a study using qualitative description; this method aims to provide a comprehensive description of a given phenomenon.[11,12] Research ethics board approval was obtained from the University of Toronto in Ontario. Through e-mail, the research assistant (M.M.S.) recruited first- and second-year residents from 2 teaching units affiliated with the University of Toronto. These units were purposely selected because they follow different models of FM exposure; one unit follows a horizontal model and the other the more traditional block model.

In the horizontal model, residents care for their own mini-roster of patients and their FM clinics are interspersed throughout their residency in what are called *half-day backs*. In the block model, residents do not follow a roster of their own, but instead spend concentrated blocks of time doing full-time FM in the office of a preceptor. As this was a qualitative study, the intent was not to compare or contrast the 2 sites; rather, the purpose for including 2 sites was to examine a wider range of experiences and thus enrich the data obtained.[11] Only 2 sites were chosen because our intent was not to generalize across all residency sites, but to obtain an in-depth description of role modeling of professionalism as it is experienced in these 2 sites.[13] Participants received a $25 coffee gift card as a token of gratitude for their participation.

The research assistant conducted one-on-one semi-structured interviews with participants. The 2009 CanMEDS-FM framework was used as a starting point to help design interview questions. Although we did not pilot-test our interview questions, the interview guide

Table 1. Components of the CanMEDS–Family Medicine 2009 professional role

KEY COMPETENCIES: FAMILY PHYSICIANS ARE ABLE TO …	EXAMPLES OF ENABLING COMPETENCIES
Demonstrate a commitment to their patients, profession, and society through ethical practice	• Exhibit professional behaviour in practice, including honesty, integrity, reliability, compassion, respect, altruism, and commitment to patient well-being • Demonstrate respect for colleagues and team members
Demonstrate a commitment to their patients, profession, and society through participation in profession-led regulation	• Demonstrate accountability to professional regulatory bodies • Participate in peer review
Demonstrate a commitment to physician health and sustainable practice	• Balance personal and professional priorities to ensure personal health and a sustainable practice • Recognize and respond to other professionals in need
Demonstrate a commitment to reflective practice	• Demonstrate the ability to gather information about personal performance, know one's own limits, and seek help appropriately • Reflect on practice events, especially critical incidents, to deepen self-knowledge

Data from the Working Group on Curriculum Review.[3]

was adapted during the interview process, as earlier interviews guided questions in subsequent interviews. The research assistant was also free to ask elaborating questions at his discretion. The interviews were an average of 25 minutes long.

We obtained demographic information regarding year of residency and training site. Because of the relatively small pool of residents from which we drew our sample, we refrained from requesting further demographic information in an effort to maintain anonymity of participants. Interviews were audiorecorded and transcribed verbatim by the research assistant. Participation was voluntary and transcripts were de-identified by the research assistant before coding and analysis. Data analysis commenced early in the interview process to allow initial analysis to guide subsequent interviews in an iterative manner.[14]

We used the CanMEDS-FM framework as an initial template for analysis of our interview data; this process is known as *template analysis*.[11] Our analysis followed a deductive or concept-driven approach that moved from explanatory models toward concrete data.[15] One substantial challenge with using a deductive approach is determining what to do with "leftover" data that do not fit neatly into the explanatory framework.[15] We planned to develop codes and subsequent themes for data that did not fit into the CanMEDS-FM framework.

An audit trail[16] was created to document decisions made along the way from data collection to data analysis and interpretation. The principal investigator (S.M.) and the research assistant coded transcripts and developed themes using NVivo coding software. These authors met regularly during the interview process to ensure trustworthiness and consistency of coding and to discuss reflexivity.[17]

Findings

Sixteen first- and second-year residents from 2 teaching sites were recruited for semistructured interviews. After template analysis with the CanMEDS-FM framework, there were 2 themes that were developed from data outside the CanMEDS-FM template: insufficient role modeling and characteristics of effective role models.

Experiences categorized by the CanMEDS-FM framework

The CanMEDS-FM 2009 framework describes 4 aspects of the professional role: commitment to ethical practice, profession-led regulation, physician health, and reflective practice.[3]

Commitment to ethical practice. Most participants could identify experiences with role modeling of ethical practice. Residents described experiences that involved role modeling of various aspects of ethical practice including integrity, commitment to patient well-being, maintaining confidentiality, honesty, disclosure of errors, and respect for others. Many examples were in the context of conflict resolution with challenging patients: "I've often seen role models, for instance, disclosing errors they've made with patients." (Participant 12, second-year resident, block model)

Profession-led regulation. About half the participants could identify examples of role modeling of profession-led regulation. Examples included witnessing their preceptors being involved in peer review or participating in regulatory bodies and other professional organizations: "You see peer review every day" (Participant 11, first-year resident, block model). Some responses suggested that participants did not fully understand the meaning of profession-led regulation; there were references to organizations such as the Canadian Medical Protective Association and Choosing Wisely Canada, which are not regulatory bodies.

Physician health. There were striking differences among residents' experiences with the role modeling of a commitment to personal health. Some residents were able to identify multiple positive examples and even believed that their preceptors explicitly sought to model a commitment to personal health.

> They share sometimes about going to their children's soccer games or what sports they are involved in themselves. They are clearly physically active, because they are walking or biking to work .... People are asking each other about a vacation, or how someone's weekend went .... I really can't think of any other way they could do more to show us their commitment to personal health. It's so visible and integrated in our daily interaction. It's very explicit and obvious that they are doing it. It's very inspiring ... to learn about how family physicians ... are balancing their life and work. (Participant 15, second-year resident, block model)

Other residents, however, had difficulty identifying experiences where they had seen a commitment to personal health modeled. One respondent expressed concerns with negative role modeling of self-care: "My supervisor ... sometimes I see her work really late hours. I wonder if she has a balanced life, or if she is taking care of herself. That worries me about the future." (Participant 7, first-year resident, horizontal model)

One resident believed that preceptors could better model a commitment to personal health by inviting residents to join them in activities of personal health.

> The way they can improve their role modeling is perhaps ask the new residents if they would like to join

> them with activities of personal health. So they could ask, for example, "Would you like to go for a run after work?" Sort of like finding a common something that you could do together—then it's not just talking about personal health, but you are kind of showing them. (Participant 12, second-year resident, block model)

Reflective practice. Residents identified multiple experiences with role modeling of reflective practice. Examples included witnessing their preceptors seek help from colleagues, reflective writing, attending morbidity and mortality rounds, and debriefing at the end of clinic shifts: "When I see my staff talking with other staff about their opinion, it gives me confidence that it's OK if you don't know something; you can … seek help." (Participant 16, second-year resident, block model)

Insufficient role modeling

Slightly more than half of the participants believed they had insufficient experiences with role modeling of professionalism. Our analysis of these responses identified 2 main areas of concern: the importance of a longitudinal relationship with a role model, and the need for close working relationships between learners and preceptors in a clinical setting.

Residents from the horizontal model in particular commented that they were exposed to a range of supervising preceptors in clinical settings. While they valued the variety of perspectives this afforded them, they believed they lacked adequate consistent time in a patient care setting with a select number of preceptors to truly appreciate and experience role modeling of professionalism. Residents also commented on the limited opportunity they had to observe their FM preceptors interacting with patients in a clinical setting.

> The difficult thing about this program is that … preceptors change, so … you can't really get in-depth, in terms of learning about how they interact with patients, or how they approach things, 'cause you only see them one time. (Participant 1, first-year resident, horizontal model)

> I find that role modeling is very limited for us …. It's very seldom that we can actually see our preceptors in family medicine looking after a patient. We are not the one watching them; normally it's the other way around. (Participant 2, second-year resident, horizontal model)

> I don't think I have a close enough relationship with the staff to know how they are dealing with it [self-care]. (Participant 7, first-year resident, horizontal model)

One resident astutely commented that certain aspects of professionalism (such as integrity) require repeated exposure to a role model over time for role modeling to be truly effective.

> For some things it's obvious what's going on. For example, if you see someone being compassionate or honest, it's easy to see, because you can see that in a clinical encounter. With things like integrity and reliability, those are built up over time and it's harder to witness that as a moment in time. So … if you knew a preceptor over a year, you would see how they are there for their patients when they need them, being reliable …. Being with the same preceptor for a significant amount of time would allow them to better role model ethical practice. (Participant 12, second-year resident, block model)

Characteristics of effective role models

Residents were asked to reflect on what characteristics represent an effective role model of professionalism based on their experiences throughout residency. Characteristics identified by at least 2 respondents included availability, clinical excellence, empathy, explicit efforts to be a role model, good communication skills, interest in teaching, self-reflection, transparency, and respect for others. Respect for others was the most often identified characteristic; 14 of the respondents described respect as an essential attribute of an effective role model. Respondents believed that role models needed to demonstrate respect not only for patients but also for learners and colleagues: "What makes us want to be like him [the preceptor] is the way he approaches others in a calm and respectful manner no matter who he is talking to." (Participant 7, first-year resident, horizontal model)

Discussion

The literature is replete with the negative effects of the hidden curriculum on learners' development of professional identities.[18-20] Reassuringly, our study found that FM residents could easily identify experiences with positive role modeling of professionalism. However, there were marked inconsistencies in resident experiences with role modeling of a commitment to personal health.

The CanMEDS-FM framework identifies a commitment to physician health as one of the core tenets of professionalism.[3] As faculty, we need to recognize the importance of self-care before we can model self-care for our residents. An international survey of medical practitioners asked participants to identify core elements of professionalism.[21] Surprisingly, self-care was not identified as an essential element of professionalism in any of the regions studied. We propose that physicians need to be reminded of the importance of attention to wellness—of its importance not only to physicians themselves, but also its relationship to patient safety. We are usually aware that we should be role models of ethical practice; we need to be aware that we also serve as role models of self-care. Further research is required to generate a better understanding of how residents are experiencing role modeling of self-care.

Residents were able to identify many experiences with role modeling of ethical practice. Of interest, many of these examples involved conflict resolution with challenging patients. As preceptors, it is imperative that we remain aware of the powerful effect these encounters can have on learners. Although challenging at the best of times, we should view these encounters as opportunities to model professionalism in a memorable way.

Our findings indicate that role modeling is most effective when residents have the opportunity to develop close working relationships with faculty over time in a clinical setting. Some aspects of ethical practice such as integrity and reliability require a longitudinal relationship for effective role modeling; these characteristics are difficult to model in a single clinical encounter. Of concern, some participants believed they did not have sufficient continuity with any given FM preceptor in a clinical setting. Residents from the horizontal model were more likely to voice these concerns. As more residency programs transition from block to horizontal models, educators should explore opportunities for longitudinal relationships in clinical settings so that learners do not miss out on the benefits of role modeling.

Residents identified multiple characteristics of effective role models. Our findings are well aligned with the work of Cruess et al,[7] who suggest there are 3 main attributes of an effective role model: clinical competence, excellent teaching skills, and positive personal qualities. In our study, residents cited respect for others as the most important personal quality of role models. A national survey of Canadian residency programs in 2011 found that residents identified a "collegial, respectful and positive" work environment as the most important feature of top residency programs.[22] Our findings can be used to devise faculty development initiatives to equip faculty to become better explicit role models of professionalism.

Future studies are required to address how best to enhance both the formal and the informal professionalism curriculum for FM residents. Birden et al posit that professionalism is best "taught" through the dual methods of role modeling and guided personal reflection.[4] Given that FM residents do experience positive role modeling of professionalism, we suggest the creation of a guided curriculum in which residents are encouraged to reflect on this experience. This reflection would serve to enhance the process of professional identity formation in our learners.[5]

Limitations

Reflexivity requires researchers to reflect on how their own beliefs, assumptions, and relationships might influence the research process.[23] Although interview transcripts were de-identified before analysis, we recognize that the evaluative relationships between the participants and some of the study investigators might have influenced the participants' comments.

Although it is tempting to use the data presented here to contrast the block and horizontal models, this qualitative study was not designed for this purpose. Furthermore, we recognize that the generalizability of our study is limited by the fact that we interviewed participants from only 2 teaching sites. Further research across a variety of sites might better elucidate the differences between the models with respect to role modeling opportunities.

Conclusion

Reassuringly, FM residents described experiences with positive role modeling of many aspects of professionalism, including ethical practice, profession-led regulation, and reflective practice. As faculty, we should seek to explicitly model a commitment to personal health so that our learners recognize its importance. To optimize the effects of role modeling, we need to ensure residents have adequate opportunity to develop close, longitudinal working relationships with faculty. In view of these findings, there is great potential to use research on resident experience with professionalism to guide both resident curriculum and faculty development.

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Contributors

Each of the authors was involved in revising the protocol and in grant application. **Dr Shuvra** conducted the interviews. **Drs Marisette** and **Shuvra** were primarily responsible for analyzing the data. **Dr Sale** is an experienced qualitative researcher who provided invaluable guidance regarding qualitative methodology. **Drs Rezmovitz, Mutasingwa,** and **Maxted** provided further perspective as family medicine educators. **Dr Marisette** was primarily responsible for drafting the manuscript. Each author participated in manuscript revision.

Competing interests

None declared

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