Role modeling in family medicine

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Dear Colleagues,

Role modeling influences learners' behaviour, professional attitudes, and career choice. Think about your first and your best role models. My first role model was in the second year of medical school; he was an internal medicine physician with a superb bedside manner and was a wonderful clinician and teacher. I wanted to do a residency in internal medicine after being with him and was devastated when he died suddenly. My best role model was a family physician who impressed me in the same way my first role model did and who conveyed so well the dimensions of continuity and comprehensiveness of care. He shared his uncertainty with me about certain clinical situations as they evolved. Equally important was the enthusiasm that he displayed when reflecting on the "surprises" in his practice on any given day.

A *role model* is defined as "a person considered to demonstrate a standard of excellence to be imitated … facilitating learning by observation."[1] The positive attributes of role models have been consistent over the years: clinical and patient care qualities ("hands on"), such as strong clinical skills, compassion, and empathy; teaching qualities ("head"), such as providing a safe learning environment, deploying a humanistic style of teaching, and stimulating critical thinking; and personal qualities ("heart"), such as self-confidence, humility, integrity, and being collaborative.[1-3] It has been suggested that competence in all 3 *h*'s is necessary for effective role modeling.[3]

Role modeling is observational and perhaps a little passive. For role modeling to be truly effective, both preceptors and students need to develop reflectivity. Reflective practitioners "think about what they do while doing" and become more deliberate, active participants.[4] Apprenticeship has been an important educational concept over the years. Under such a model students or residents learn "through participation in an environment, where 'ways of being' are modeled."[5] They use schemas to capture their knowledge, attitudes, and experiences of events, and when faced with a new situation, they use such schemas to "understand the new experience."[5] Current education thinking is about active participation in "situated learning," in which learning occurs "in the context of practice, including knowledge, skills, and social norms."[5] In this model, professionals learn by "participating in, and gradually being absorbed into, communities of practice (in this case, the medical profession)"[5] and develop identity in relation to it. Situated learning is considered an enhancement of apprenticeship in that, as learners become full participants and build and revise their schemas in the community of practice, the community of practice also changes simultaneously, and the learner adds to the community.[5] Although I was not aware of the educational theory behind this at the time, I now realize that this is the educational experience that I had and benefited from.

The CFPC has adopted a preceptorship model (clinical and competency coaching), in which learners benefit from a continuity relationship with a family physician preceptor. This is also articulated in 1 of the 3 *C*s of the Triple C curriculum (*continuity* of education and patient care).[6] This required preceptorship is further described in the CFPC's *Red Book* training standards.[7] The CFPC also created the *Fundamental Teaching Activities in Family Medicine* framework, which provides an outline of responsibilities, role modeling tips, and a road map to becoming a reflective practitioner, to support preceptors and teachers in this important work.[8]

I look forward to celebrating with many of you the 40th anniversary of the Section of Teachers next month at Family Medicine Forum, and recognizing the wonderful family medicine role models who do superb work every day in communities large and small across the country.

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