# MODULE EIGHT

# PROFESSIONALISM IN MEDICAL EDUCATION

## (Including the evolution of professionalism in General Practice and General Practice Training)

**QUESTIONS ANSWERED**

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| **WHAT** | • **are the important professional attributes I need to carry out my ME responsibilities effectively?**<br>• **are the important aspects of general practice as a profession?** |
| **WHY** | • **is it important to emphasise professionalism as part of the ME role?** |
| **WHEN** | • **do professional attributes in my ME role most often need to be demonstrated and exemplified ?** |
| **HOW** | • **do I demonstrate professionalism in the way I carry out my responsibilities?**<br>• **Has professionalism in medicine and general practice evolved?** |
| **WHERE** | • **do professional attributes in my ME role most often need to be demonstrated and exemplified ?** |
| **WHO** | • **are the critical members of the team for reinforcing professional attributes?** |

In parallel with the professionalism they demonstrate as a clinician, MEs need to be able to demonstrate their professionalism as educators. The ME needs to reflect on and clarify their own professional values and be competent in demonstrating a duty of care to registrars, supervisors and other participants involved in GP training. The ME needs to work effectively as as a member of the RTP team and may face competing role demands. To be an effective role model for registrars, MEs need to be able to convey a strong commitment to the foundations of general practice as a professional discipline and an understanding of the evolution of general practice and GP vocational training.

**What does it mean to be a professional?**

Whilst the answer to this complex question is clearly beyond the scope of this module, a professional can be considered someone who:

- Has high (professional) knowledge and skills and takes responsibility for maintaining them
- Demonstrates a "Duty of Care" to those they interact with
- Behaves ethically

This module emphasises the importance of conveying a sense of professionalism to registrars. It advocates that MEs adopt two approaches in doing this:

1. MEs need to demonstrate professionalism in the way they carry out their role as educators and mentors.
2. MEs need to assist registrars to understand and become committed to general practice as a professional specialism in medicine.

**THE ME AS A PROFESSIONAL**

As a GP these days you are likely to have a reasonably strong sense of your professional identity. In general GPs have every reason to feel confident that they belong to a vocational group recognised in society as a legitimate profession having well-trained members for the role they perform.

You will understand that your professionalism as a clinician hinges upon your:
clinical knowledge and skills and the maintenance of them
duty of care to your patients and the broader community
commitment to the profession of General Practice
ethical behaviour expected of a GP.

By comparison as a newly appointed ME, your understanding of the ME role as a professional activity may be less clear. What are the components of demonstrating professionalism as a ME and how are they related to my clinical role?

It is best to think of professionalism in medical education as an **extension** of the professionalism required as a clinician. In addition to the professional knowledge and skills you have as a clinician you are required to have knowledge and skills as an educator and to maintain them.

In addition to the duty of care you have as a clinician you have a duty of care as an educator to the registrar, the registrar's patients, the supervisor and the supervisor's practice and to the RTP and the Australian General Practice Training Program. The principles of behaving ethically will be the same for a clinician and a medical educator but they will be brought into play in new contexts that you may not be familiar with.

Some of the extended knowledge and skills required as a ME have been considered in previous modules.

**What are the competencies a ME must possess to demonstrate professionalism?**

The project team was particularly mindful of the need to incorporate professionalism into the repertoire of skills and attributes that a newly appointed ME should develop as part of their role. For this reason the ME competencies framework presented in module 3 includes a substantial section on demonstrating professional and ethical behaviour.

The list of competencies invites you to think about your ME role in terms of the professional and ethical standards and duty of care you have toward key groups of people that you deal with. You may find some of the duties of care listed below surprising or even a little confronting.

**ME Competencies related to professional and ethical behaviour**

**3. Professional and Ethical**
Demonstrate understanding of, and the ability to, work within a professional and ethical framework consistent with the standards expected as a medical educator

**3.1 Duty of care**
Demonstrate ability to exercise:

**3.1.1 Duty of care to self**

a) a healthy integration of work with other aspects of life
b) the capacity for self reflection and change
c) manage the personal impact of role conflicts
d) recognise the nature and limitations of knowledge, skills and attitudes

**3.1.2 Duty of care to patients**

a) respect and concern for patients (specifically when involved in direct clinical discussion with registrars) - e.g. to address possible adverse outcomes
b) where necessary implement policies and processes to identify registrars with serious deficiencies

**3.1.3 Duty of care to registrars**

a) commitment to optimise educational and career outcomes for registrars
b) facilitate registrar's decision making processes at the various stages of their professional development by providing relevant information and advice
c) respect and concern for registrar well being
d) identify and appropriately respond to individual registrar circumstances that may impact on training and/or wellbeing i.e. obstacles to progression towards safe and independent practice
e) respect for difference and diversity among registrars

**3.1.4 Duty of care to practices and supervisors**

a) understands the impact of involvement in training on practices and responds appropriately when required
b) courtesy, respect and concern for supervisors (and training practices) as educational colleagues
c) develop and maintain good communication links with supervisors and practices
d) support practices in providing safe and effective training environments

**3.1.5 Duty of care to organisation/employer**

a) work as part of a broader team to deliver organisational goals
b) identify and manage potentially conflicting roles

**3.1.6 Duty of care to communities**

a) understanding of Australian health care, including workforce needs, health system, specific regional issues and marginalised populations e.g. Indigenous, migrant, rural and remote)
b) integrate this knowledge into other aspects of the ME role
c) takes community needs and resources into consideration during program planning, development and delivery
d) awareness of the importance of primary care for the health of populations
e) appropriately utilise community participation in training
f) understanding of the impact of the training program on its community

**3.1.7 Duty of care to the profession**

a) understanding of, leadership and advocacy in, and enthusiasm for, the discipline of general practice
b) understanding of, leadership and advocacy in, and enthusiasm for medical education
c) advocacy for quality improvement in general practice and GP education
d) promote appropriate behaviour in others by:
    - role modelling reflective and evidence- based practice;
    - enthusiasm for the discipline;
    - educational, personal and professional integrity; and
    - modelling the dual professions of educator and medical practitioner
e) mentor less experienced educators
f) engagement with professional bodies e.g. Colleges

**3.2 Professional and personal development**

Demonstrate:

a) a commitment to regular personal and professional development, both clinically and educationally
b) a commitment to medical education, at local, regional and national levels
c) understanding of educational theory and principles
d) a commitment to applying and enhancing the evidence base of medical education, including involvement at various levels of evaluation and research
e) a commitment to educational leadership
f) engagement in the broader scholarly debate in medical education, including theory, research findings and new technologies

Four major characteristics of ME professionalism and ethical behaviour can be identified in the above statement of competencies:

1. Behaving ethically
2. The special duty of care that arises when an ME provides expertise and advice to others involved in GP training
3. Reflective and self-appraisal skills; and
4. Maintenance of professional standards.

**What is ethical behaviour in the context of medical education?**

Professional ethics provides a set of principles which makes the practitioner's behaviour consistent, reliable and trustworthy. For MEs, ethical behaviour is the foundation for developing effective relationships with, and exercising a duty of care towards other participants in GP training.

The core elements of ethical behaviour are:

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| *Clarification:* | The capacity to identify the key elements of a situation or problem |
| *Alternative perspectives:* | The capacity to recognise and differentiate between different cultural perspectives on how we should behave. |
| *Analysis:* | The capacity to weigh up and balance the key considerations in determining a course of action |
| *Justification:* | The willingness and ability to provide a defensible explanation for the decisions you make and the conclusions you draw |
| *Integrity:* | The demonstration of personal integrity and honesty |

The following factors are relevant in behaving ethically as a ME:

- Showing respect and courtesy
- Paternalism vs client autonomy
- Conflict of interest
- Telling the whole truth cf. hedging or softening cf. Untruth
- Beneficence (actively doing good) cf. Non-maleficence (doing no harm)
- Justice – fairness and equity in the way people are dealt with
- Acknowledging rights
- Confidentiality and privacy
- Rights to information before consenting to further action
- Acknowledging rights to complain and appeal
- Rights to obtain opinions from others

- Recognition of own limitations
- Appropriate follow up and reporting

***Activity 8.1***

## *MEs Behaving Ethically*

Consider the situation where as a ME you have been asked to assess a registrar because there are concerns about the registrar's competence. This can be a particularly high stakes assessment for the registrar and it is therefore particularly important that it is conducted ethically.

Consider the core elements of ethical behavior list above.

In undertaking the assessment, how will the core elements of ethical behaviour be met by you?

Use *Tool 8.1: Scenario: Ethical Element Analysis* to complete this activity. Once you have finished it discuss your answers with a senior ME.

**How does a ME demonstrate a duty of care to the groups involved in GP training?**

"Duty of Care" is a legal concept. In medicine, duty of care refers to the obligation the doctor has to provide a reasonable standard of care to the patient. As a GP, when you exercise a duty of care your intent is the best outcome by being mindful of important health concerns and acting upon them in the best interest of the patient. Your focus is on what is best for the patient.

For example, consider the patient who presents with chest pain just before your planned work finishing time. Your aim will be to ensure any myocardial damage is detected and minimised using your knowledge and skills before your own wish to go home is met. Ideally you can meet the need to look after yourself at the same time by arranging appropriate handover!

As mentioned previously, MEs have an **extended** duty of care beyond that of the clinician. By adapting the concept of duty of care to the ME role, it highlights the importance of:

a) possessing a range of educational competencies to perform the role effectively, and
b) using their knowledge and skills in their relationships with the multiple participants involved in the GP training process.

The ME needs to take into account a range of factors in determining their duty of care toward any of the groups involved in GP training. The ME also needs to be aware that this may involve reconciling or balancing competing priorities between the groups.

***Duty of care to patients:***

As a clinician you already have an understanding of your duty of care through reflection on your own experience. From time to time, MEs may be confronted with some uncomfortable choices between the duty of care they owe to registrars versus patients when a registrar is not providing adequate patient care. This means you need to think about different approaches from possibly competing perspectives. Other parts of this module discuss medical professionalism.

***Duty of care to registrars:***

A prime focus of an educator's role is the learners – in this case the registrar. Clearly whatever actions you take carry implications for the registrar. You are there to facilitate the registrar's learning by observing, providing constructive feedback and guidance on what is needed to improve their future performance. Modules 5, 6 and 7 are all directly related to your role in facilitating the learning of registrars.

***Duty of care to practice and supervisors:***

Training practices and supervisors are the essential component of GP training. RTPs have an obligation to practices to do what they can to ensure registrars are prepared for practice and to deal with problems as they arise. ME have a pivotal role in maintaining constructive relationships between the RTP and teaching practices and supervisors. Modules 3 and 4 have relevant information about your role in this regard.

***Duty of care to the community:***

The practice needs to feel that its reputation in the community remains in good standing. The community's interest is to be able to get quality medical care and attention which addresses their need when they require it. Practices accept the obligations associated with providing training and supervision for registrars they employ. Teaching practices also have an expectation that registrars will be a part of their workforce and contribute to providing medical services to the community. The ME has a role in reinforcing registrars' awareness of community expectations and their obligations to contribute to the practice in its community.

***Duty of care to the RTP:***

MEs are the most important contact registrars have with their RTP consequently MEs have a central role in conveying the RTPs policies and procedures and giving direction about program requirements to registrars. The ME's duty of care is to acknowledge the contribution of all members of the RTP staff team, ensure that the information they provide is accurate and consistent, and that they reinforce program requirements. Module 4 can give you more information in this area.

***Duty of care to the profession:***

MEs need to see the potential that exists in any registrar contact to promote the philosophies, values and unique characteristics of general practice as a professional discipline. Training involves socialisation of registrars into the role and culture of general practice and the ME has a crucial role in assisting this process. Other parts of this module may be helpful to you in this regard.

**What if there are conflicting duties of care?**

The broader duties of care of a ME compared to those of a clinician can lead to greater complexity and potential for conflict between competing duties of care. A conflict between duties of care is more commonly known as an ethical dilemma.

Activity 8.1 highlighted ethical behaviour as an important component of managing conflict between duties of care. The core elements of clarification, alternative perspectives, analysis, justification and integrity can be used to find your way through the conflict. However, two medical educators behaving ethically may come to different decisions regarding how to handle the same conflict. Why is this so?

It turns out that all duties of care are not equal and the relative weights we give to each duty of care may differ. Again it is easiest to illustrate this with an example you are all familiar with as a clinician.

Consider the situation of a patient who requests a test that a clinician does not think is clinically indicated, eg. a patient who is a smoker requesting a chest X-ray for a 3 day history of cough because of fear of lung cancer.

Some doctors will never order a test that they do not think is indicated and will justify this on the basis of their duty of care to the community to restrain unnecessary costs in the health care system. Other doctors will order any test a patient requests and may provide the justification that it is patient-centred medicine.

Most doctors will generally only order tests that are clinically indicated but will under certain circumstances accept the patient's request to order a test they do not think is clearly indicated. Even within this majority group, what are deemed acceptable circumstances will vary.

In this example different clinicians have given different weights to the conflicting duties of care – duty of care to the patient (patient centred medicine) and duty of care to the community (reduce unnecessary costs).

*Activity 8.2*

## *My Ethical Framework*

The relative weights we each give to conflicting duties of care will be due to our own individual ethical framework. This is why two medical educators may have two differing responses and solutions when facing the same ethical dilemma.

It is important to have a clearer understanding of the genesis of your own ethical perspective to enable you to behave ethically.

Your ethical framework will have formed from many aspects, some of which are listed in *Tool 8.2: My Ethical Framework Influences.* You may wish to include some others.

Use this tool to record your answer for each of the core elements below and discuss this with a Senior Medical Educator.

Although we can each come to our own position on any ethical dilemma, we are likely to be strongly influenced by our peers. Our own ethical framework is, to some extent, moulded by the ethical frameworks of those to whom we relate most closely.

During our undergraduate and postgraduate medical training we learned to respond professionally in a similar manner to other GPs. Some of this learning occurred through observing the professional behaviour of other GPs, in particular observing how they responded to ethical dilemmas.

It is likely as a new ME you will not have the same opportunity to follow around an experienced ME, observing their professionalism, as you had as an undergraduate trailing around an experienced doctor. How can learning about how MEs respond to ethical dilemmas be "fast-tracked"?

In the activities 8.3 to 8.5 you will be challenged by conflicting duties of care identified as common by the experienced MEs in the project group. It will be useful for you to consider these scenarios and discuss them with an experienced ME. In this way you will uncover the ethical framework of other MEs and refine your own responses.

*Activity 8.3*

## *Horns of a Dilemma*

Scenario 1.
*You are on a teaching visit. You already know the registrar is struggling and that the supervisor is not happy with the registrar. As you are sitting in, the consultation is not going well and you feel the patient is not being managed optimally. You are incidentally also worrying about a patient you saw in your practice yesterday.*

Consider this situation from a theoretical perspective:

- What are the conflicting duties of care?
- What extra duties of care are there compared to those of a clinician?
- How will the core elements of ethical behaviour (clarification, alternative perspectives, analysis, justification and integrity) help me resolve this conflict?

Consider this situation from a practical perspective:

- Should I interrupt and take over the consultation? What are my options?
- How would I effectively provide feedback to the registrar taking into account the registrar's feelings while conveying what you need to say?
- Should I discuss this with the supervisor and should the registrar be informed of this discussion?
- What should be included in my RTP report?
- What is likely to be in the best short term and long term interest of the registrar?
- What do you need to do ascertain whether the registrar needs further remediation?
- What do you need to do ensure that the registrar's progress during training can be monitored effectively?

<u>Some further scenarios to consider</u>

*What if the doctor was prescribing amoxycillin and the patient was allergic to penicillin?*
*What if it was doxycycline and no check had been made regarding patient pregnancy?*
*What if you feel an antibiotic was not required for the sore throat presented?*

*Activity 8.4*

## *A Further Ethical Dilemma*

Scenario 2

*Having finished the teaching visit with some significant concerns about the registrar's competence you are now sitting with the supervisor who looks relieved to see you. He says he hopes you can sort this out for him. They are very short of doctors and can't afford to lose any doctors particularly for their after-hours roster, but this registrar seems to be creating even more work for the practice.*

Consider this situation from a theoretical perspective:

- What are the conflicting duties of care?
- How will the core elements of ethical behaviour (clarification, alternative perspectives, analysis, justification and integrity) help me resolve this conflict?

Consider this situation from a practical perspective:

- What are my options if a Registrar is not performing competently?
- What should be taken into account in choosing between the various options?
- How can I support the relationship between Registrar and Supervisor?
- To what extent is the RTP responsible for the workforce needs of the practice?
- Is there anyone else in the practice who should be involved and how?
- Who do I inform at the RTP? – Support staff, RLO, Senior Medical Educator?
- Will the concerns of the broader community be met? Under what circumstances should the Medical Practitioners Board be informed?
- How will my behaviour in resolving this problem impact upon the Registrar and Supervisors learning about professionalism?

Some further scenarios to consider

*What if during the teaching visit the practice staff had kept trying to squeeze extra patients in as they were so busy and this impacted upon the learning experience of the visit? What if the registrar was unhappy with the practice because the required teaching time was not being provided? What if you thought the registrar was depressed?*

A DVD produced by Genevieve Yates (CSQTC) "What Would the Coroner Think?" is a very useful resource for discussion of conflicting duty of care issues faced by MEs and supervisors. Here is the link:

http://www.youtube.com/watch?v=OpZtTzCUSvI&feature=channel_page

The balancing act between the degree of program direction versus learner direction was discussed in Module 5: Teaching & Learning Principles. It was suggested that this balancing act is reconciled by using learning plans and learning portfolios to provide a significant level of learner self-direction within a broad framework of education and assessment requirements.

From a professionalism perspective, resolving your perceived duty of care to registrars and the RTP program requirements can become a dilemma. If you tend to the view that registrars should have maximum flexibility to determine their own learning and training experiences (rather like the early stages of the FMP – see "Milestones in the Evolution of Australian GP Training" below), presumably you would place more emphasis on your duty of care to registrars by letting registrars do what they want. If you tend to the view that GP training involves learning activities which should be provided through a structured program delivered by experienced and qualified practitioners and educators, then presumably you would err on the side of your duty of care to the patients, community and the RTP program.

***Activity 8.5***

## *Just When You Thought it was Safe to Return to the Office .....*

Scenario 3:

*You arrive at the RTP for an education team meeting where an animated discussion is in progress about the registrar evaluations of last year's workshops. It is obvious that the lowest rating sessions are on Indigenous Health and critical thinking and research. Some educators feel strongly that the RTP should be responding to what registrars want by taking a "learner centred approach" and include more exam focussed topics and activities. Others feel a responsibility to provide an educational program that provides what they need rather than just what they say they want regardless of the feedback.*

Which side of the fence would you sit on? What are your reasons?

How would you support your argument?

You might like to role play this discussion with your colleagues.

In a team meeting of this nature what sort of role would you take?

The above scenario illustrates an aspect of training about which there has been protracted debate (refer below to the box "Milestones in the Evolution of Australian GP Training" to get a flavour of these debates).

MEs vary in their own values and attitudes about these matters so it worthwhile pausing for a bit of self-reflection. In thinking about where your duty of care lies, you are likely to want to consider questions (sound familiar?) such as:

- What were the problems with these sessions? Content? Presentation?
- Why were these sessions included? Still important?
- When were they conducted? Is it a timing issue?
- How were the sessions conducted? Could it be improved?
- Where were they conducted?
- Who ran them? Were they appropriate?

Asking questions such as these undoubtedly will lead you to become better informed about the evidence supporting the need for these sessions, contract requirements, curriculum requirements, personal views, public health priorities, local relevance, time constraints and competing interests.

When it comes to professional and ethical issues and viewpoints on where your duty of care may lie, different viewpoints may be equally defensible and there are not necessarily absolutely right or wrong positions. Consequently, in an ME or RTP staff team, it is often important to acknowledge that there may be different viewpoints and that accommodation, compromise and consensus is the most appropriate way to proceed.

**How does the ME demonstrate self reflection and appraisal?**

Critical self-reflection and insight into one's professional and personal strengths and weaknesses and a willingness to seek to learn and improve are a fundamental part of being a professional. Schon describes this as an integral part of the "artistry" of being a reflective practitioner. Practitioners who excel in their professional area go beyond technical competence into a process of continual reflection about their performance in problematic situations and contexts. These professional attributes are combination of:

- understanding and awareness of principles of being a reflective practitioner
- skills in lifelong learning, critical appraisal, self-reflection, and more generally research and evaluation
- skills in professional networking, teamwork and fostering collegial support
- skills in time management and self-care
- values and attitudes which reflect an appreciation of the importance of these attributes

These attributes are best developed through discussion and feedback from colleagues and peers and by self reflection. Adopting a positive commitment and openness to continuous learning is important in all facets of professional life. However it is essential with ethics and values, because without questioning and challenging value positions and ethical stances people can

develop entrenched stereotypes which are the antithesis of openness to critical reflection and life-long learning.

***Activity 8.6***

## *ME Ethical Self-Assessment*

Refer to *Tool 8.2: Ethical Behaviour Self-Assessment Tool.*

Reflect on a specific registrar contact meeting or ECTV in terms of the professional and ethical behaviour you demonstrated.

Use the tool to rate yourself and record some ways you may strive for self-improvement.

**How does the ME demonstrate commitment to professional standards?**

The ME also needs to demonstrate a commitment to their own on-going personal and professional development. This applies in relation to maintaining and improving both their clinical and their medical education knowledge and skills. Professional standards in general practice are well documented; whereas in medical education it is more a case of gleaning information from the literature. Developing a professional approach to medical education involves striving for deeper understanding of the principles of sound educational practice, educational evaluation and research and active participation in scholarly debate about educational issues.

There is an excellent resource developed by General Practice Training Tasmania for registrar and supervisors: *Professional Attributes and Ethical Behaviour Module.* This module has information, examples and resources of relevance to the topic of ME professionalism. If you would like to refer to it follow this link:

GPTT Professional Attributes module.doc

**PROFESSIONALISM IN MEDICINE**

The following link is to an article entitled *Professionalism and Medicine* that examines the ethical and philosophical foundations of medicine and professionalism and includes an important discussion of medicine's role and responsibilities in contemporary society. Additionally there is a discussion on teaching professionalism which among other things underscores the importance of role modelling and reflection in practice.

http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2504270

Social commentators point to the inherent contradiction between self-interest versus altruism in accounting for the motivations and actions of medical professional groups. For an analysis of the issues facing contemporary medical professions refer to the following link:

http://www.mja.com.au/public/issues/177_04_190802/cru10332_fm.html

In recent times a *Charter of Medical Professionalism* has been developed. The charter emphasises the concept of a social contract. An outline of the charter is shown below.

**Charter of Medical Professionalism**

**Preamble**

*Professionalism is the basis of medicine's contract with society.* It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession.

**Fundamental Principles**

*Principle of primacy of patient welfare.*
This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician–patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.
*Principle of patient autonomy.*
Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care.
*Principle of social justice.*
The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

**A Set of Professional Responsibilities**

*Commitment to professional competence*.
Physicians must be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality care. More broadly, the profession as a whole must strive to see that all of its members are competent and must ensure that appropriate mechanisms are available for physicians to accomplish this goal.

*Commitment to honesty with patients.*
Physicians must ensure that patients are completely and honestly informed before the patient has consented to treatment and after treatment has occurred. This expectation does not mean that patients should be involved in every minute decision about medical care; rather, they must be empowered to

decide on the course of therapy. Physicians should also acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide the basis for appropriate prevention and improvement strategies and for appropriate compensation to injured parties.

*Commitment to patient confidentiality.*
Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to disclosure of patient information. This commitment extends to discussions with persons acting on a patient's behalf when obtaining the patient's own consent is not feasible. Fulfilling the commitment to confidentiality is more pressing now than ever before, given the widespread use of electronic information systems for compiling patient data and an increasing availability of genetic information. Physicians recognize, however, that their commitment to patient confidentiality must occasionally yield to overriding considerations in the public interest (for example, when patients endanger others).

*Commitment to maintaining appropriate relations with patients.*
Given the inherent vulnerability and dependency of patients, certain relationships between physicians and patients must be avoided. In particular, physicians should never exploit patients for any sexual advantage, personal financial gain, or other private purpose.

*Commitment to improving quality of care.*
Physicians must be dedicated to continuous improvement in the quality of health care. This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patient safety, minimize overuse of health care resources, and optimize the outcomes of care. Physicians must actively participate in the development of better measures of quality of care and the application of quality measures to assess routinely the performance of all individuals, institutions, and systems responsible for health care delivery. Physicians, both individually and through their professional associations, must take responsibility for assisting in the creation and implementation of mechanisms designed to encourage continuous improvement in the quality of care.

*Commitment to improving access to care.*
Medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care. Physicians must individually and collectively strive to reduce barriers to equitable health care. Within each system, the physician should work to eliminate barriers to access based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician, without concern for the self-interest of the physician or the profession.

*Commitment to a just distribution of finite resources.*
While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources. They should be committed to working with other physicians, hospitals, and payers to develop guidelines for cost-effective care. The physician's professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures. The provision of unnecessary services not only exposes one's patients to avoidable harm and expense but also diminishes the resources available for others.

*Commitment to scientific knowledge.*
Much of medicine's contract with society is based on the integrity and appropriate use of scientific knowledge and technology. Physicians have a duty to uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence and physician experience.

*Commitment to maintaining trust by managing conflicts of interest.*
Medical professionals and their organizations have many opportunities to compromise their professional responsibilities by pursuing private gain or personal advantage. Such compromises are especially threatening in the pursuit of personal or organizational interactions with for-profit industries, including medical equipment manufacturers, insurance companies, and pharmaceutical firms. Physicians have an obligation to recognize, disclose to the general public, and deal with conflicts of interest that arise in the course of their professional duties and activities. Relationships between industry and opinion leaders should be disclosed, especially when the latter determine the criteria for conducting and reporting clinical trials, writing editorials or therapeutic guidelines, or serving as editors of scientific journals.

*Commitment to professional responsibilities.*
As members of a profession, physicians are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards. The profession should also define and organize the educational and standard-setting process for current and future members. Physicians have both individual and collective obligations to participate in these processes. These obligations include engaging in internal assessment and accepting external scrutiny of all aspects of their professional performance.

Refer to the following link for the full text of the charter.

http://www.annals.org/cgi/content/full/136/3/243

The emphasis of medical professionalism in the above charter is on professional competence, relationships with patients, quality and access to care, effective use of resources, knowledge advancement, and professional behaviour.

Teaching is an important element of being a medical professional. The obligation to teach students, trainee doctors, colleagues, and patients is a part of being a GP. When you take on a ME role it is equally as important to consider medical education as bound by similar commitments to professionalism as you are in your clinical role. This is why we have suggested the concept of "dual professionalism": the ME as a professional medical practitioner and as a professional educator.

*Activity 8.7*

## *Chartered Professional*

Refer to the Medical Professionalism Charter. If you were asked to develop a similar charter for medical education what would it contain?

Do you think it would be a worthwhile exercise for AMEN to sponsor the development of a ME Professionalism Charter? Why or Why not?

The following link may also be of interest to you because it shows a presentation from a former GP, President of the British General Medical Council, and Chairman of the Picker Institute Europe on medical professionalism with some international data on various aspects of patient care.

http://www.qip.com.au/uploads/files/02E5DDE0_P1-_Sir_Donald_Irvine_-_Patient_Centred_Professionalism.pdf

The Picker Institute Europe is a charitable organisation whose objectives are to promote public health and standards of patient care, advance education for healthcare practitioners, and undertake research into health care from a patient's perspective. More details can be found at the following link

http://www.pickereurope.org/

**GENERAL PRACTICE AS A PROFESSION**

This module has been structured around two major approaches to professionalism in the ME role.

1. MEs need to demonstrate professionalism in the way they carry out their role as educators and mentors, and
2. MEs need to assist registrars to understand and become committed to general practice as a professional specialism in medicine.

The first half of the module has focussed primarily on the professional and ethical competencies MEs need to demonstrate as part of their role.

This section examines the ME role in promoting registrar understanding of, and commitment to general practice as a professional specialism.

**Why is the ME role important in promoting general practice as a profession?**

Unlike some other teachers, nearly all MEs practice in the discipline they teach. When MEs demonstrate professionalism as a clinician and as a teacher, they are teaching by role modelling.

As a teacher of general practice you are a leader in the profession. You will spend time reflecting upon the important elements of general practice. You will shape the GPs of tomorrow.

In order to be effective leaders and role models for registrars, MEs need to be able to convey a strong commitment to the foundations of general practice as a professional discipline and an understanding of the evolution of general practice and GP vocational training.

A brief overview of the history and philosophy of General Practice and GP training is provided in the remainder of this module and there are references for you to explore this background to your role further.

***Activity 8.8***

## *Questions of Professional Status*

What is your assessment of how well general practitioners meet their professional responsibilities (as listed in the Medical Professionalism Charter)?

What are the main points you would seek to convey to registrars in your teaching and role modelling about how to they can demonstrate their professionalism?

It could be valuable to lead a discussion on these matters with your colleagues.

Here's a further suggestion: prepare a brief presentation for a future registrar workshop on "General Practice as a Profession – Implications for Your Training". If the opportunity presents itself try it out with your ME colleagues.

**How has general practice evolved as a profession?**

To understand professionalism we need to understand how the concept of being a professional evolved. Along with divinity and law, medicine was one of the first areas of activity to evolve from artisan or trade status to gain recognition as a profession. The following link provides an account describing the interplay of social, professional and political influences contributing to the development of medical professional groups. The machinations of the physicians, surgeons and apothecaries competing for legal and professional status and dominance makes for fascinating reading!

History of the modern medical profession - article.rtf

As you peruse the above article you may like to pay particular attention to the following points which relate to the development of general practice in the United Kingdom.

**Historical Development of General Practice in Britain**

- Antecedents can be traced back to the apothecaries of the 16th century.
- Apprenticeship model of training.
- The largest group of medical practitioners in society but traditionally lower in the pecking order than the physicians and surgeons
- More exposed to direct competition from unqualified practitioners
- Act of 1815 provided that:
    - apothecaries became the first professional group to establish a modern system of qualification and registration as protection from unqualified practitioners
    - general medical practitioners had to pass the examination of the (low status)Society of Apothecaries.
- Medical Act of 1858:
    - Established the forerunner of the General Medical Council (and the Australian Medical Council)
    - Introduced the concept of the registered medical practitioner
    - Led to significant improvements in the quality of medical education, the demise of traditional apprenticeship training and the expansion of hospital medical schools with university affiliation.
    - consolidated the status of the apothecaries but didn't really change the pecking order with the Royal College of Physicians remaining as pre-eminent.
- The growth of hospitals which accompanied improvements in aseptic techniques and anaesthetics laid a foundation for them to become preferred by people for medical care.
- Status and livelihood of apothecaries, now more popularly known as general practitioners, was increasingly being undermined.
- The Association of General Practitioners was formed in 1886
- AGP successfully promoted acceptance of GP referral to a specialist.
- Primary care increasingly becomes the domain of the GP.
- Dichotomy between (more prestigious) hospital based medical expertise and (lower status) general practice became increasingly reinforced. Only in rural areas did GPs retain hospital visiting rights.
- Formation of British College of General Practitioners (later Royal) 1953
- Formation of Australian College of General Practitioners (later Royal) 1958.

The formation of the colleges of GPs can be seen as part of efforts to respond to the increasing professional power of hospital based medical specialties. The GP colleges were strongly focused

on promoting high standards of practice, undergraduate and postgraduate education in general practice and research as a means of rectifying the "cinderella" status of general practice in medicine. The impetus for change in the post world war two in Britain and Australia came with the introduction of the national health scheme in Britain and considerably later, and after much resistance from the specialist dominated AMA, the introduction of Medicare in the early 1980's in Australia. These changes reinforced the central role of the community based GP as the point of entry for patients to obtain medical care.

For a comprehensive account of the evolution of general practice in the post world war two period in Australia refer to:

http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-publications-gpinoz2000-index.htm/$FILE/chpone.pdf

**How did GP training evolve in Australia?**

The above link also provides insight into the development of vocational training for general practice. Prior to the 1960s there was no formal training for general practice in Australia. Typically recently graduated doctors would complete hospital residency and then spend some time in community practice before making a decision to enter training in one of the recognised specialisms. With the growth of hospitals from 1950 onwards increasingly the trend was for young graduates to enter specialist training directly after their mandatory hospital time. This meant that fewer graduates were entering general practice and those that did were increasingly likely to be drop-outs from specialist training. The "cinderella" status of general practice was exacerbated by these developments. In this context, the beginnings of GP training emerged:

| **Milestones in the Evolution of Australian GP Training** | |
|---|---|
| ***Early Initiatives- Laying the Foundations*** | |
| 1962. | ACGP proposes 5 year vocational training program |
| 1964 | Continuing education program for all members developed |
| | Graduate training program for those entering general practice developed |
| 1965 | RACGP membership admission amended to require 3 years approved training in general practice after hospital internship |
| 1966 | Advanced training courses offered |
| 1967 | College examination developed and trialled |
| 1968 | First formal examination undertaken |
| | College vocational training program announced |
| 1970s | Various state funded GP training schemes (hospital funds used for GP rotations for RMOs) |
| ***Formative Years – voluntary model, educationally innovative, no formal assessment, strong ideological commitment to self-directed learning equated with minimal program direction and maximum flexibility*** | |

1973 RACGP commences Family Medicine Program (FMP Mark 1) with Commonwealth Government funding
Program features and structure:
- 4 years duration
- 2 years hospital rotations including 1 in family practice
- 2 years advanced training in accredited family practices
- No formal examination
- Voluntary participation by trainees

1970s Big growth in trainee numbers
1976 National Trainee Association established
1982 External Hurley-Cummins review criticises program as too unstructured with no formal assessment and recommends funding much shorter training period

***Transformation – reduced funding, voluntary model but laissez-faire approach to self-direction modified by increased program direction through learning contracts, beginnings of more systematic formative and summative assessment***

1984 Commencement of FMP Mark 11
Program features and structure:
- variable duration (maximum federally funded 9 months)
- 2 years hospital rotations post intern (State funded)
- 6 months in supervised GP terms with possible 3rd term in special cases (Federally funded)
- Further GP experience up to 2 years (unfunded)
- Learning contracts introduced
- Certificate of Satisfactory Completion of Training (CSCT) introduced
- Voluntary participation by trainees

1985+ Growing support for vocational registration and mandatory training
1987 RACGP commissioned external medical education expert, Prof Steve Abrahamson recommends College examination as end-point of training assessment, vocational registration and improved accreditation of training practices

***Consolidation – first big step towards mandated training for general practice, greater degree of program direction, introduction of GP training curriculum, more systematic and rigorous approaches to teaching and supervision, greater focus on evaluation and quality improvement, strengthening of rural training in a context of strong political turmoil between RACGP and emerging ACRRM.***

1989 Federal legislation to introduce vocational registration for GPs
1990+ Commencement of FMP Mark 111.
Program features and structure:
- Minimum of 3 years duration
- 12 months in supervised GP terms
- Formative and summative assessment introduced
- ECTVs adopted nationally
- College examination as end-point summative assessment

1990+ Systematic national program evaluation established

| | |
|---|---|
| 1992+ | Growing emphasis on rural training initiatives and advanced training pathways |
| 1993 | FMP is renamed RACGP Training Program |
| 1996 | Graduate Diploma in Rural General Practice offered by RACGP as an advanced year of training |
| 1997 | RACGP Training Program curriculum published |
| 1997 | Federal legislation to restrict Medicare provider numbers to doctors with recognised specialist qualifications or in recognised training programs |
| 1997 | Australian College of Rural and Remote Medicine established |
| 1998 | Ministerial Review of General Practice Training recommends greater regionalisation and cooperation between RACGP and ACRRM |
| ***Re-organisation – GPET established, increased funding, regionalised model of training through 20 + RTPs, increased emphasis on program direction, formative and summative assessment, large increase in IMGs to rural training, RACGP (and subsequently) ACRRM standards and curricula to be observed, FACRRM accepted as alternative for vocational recognition, increased emphasis on workforce, and responding to government policy.*** | |
| 2000 | Minister announces reforms to GP training system |
| 2001 | GPET established to take over from the RACGP and set up a regionalised model to deliver AGPT |
| 2002 | Regional Training Providers established under funding agreements with GPET. Training to be provided in line with RACGP curriculum, standards and assessment requirements |
| 2006 | AMC accreditation of RACGP education standards and processes |
| 2007 | ACRRM Fellowship and training pathway (through AGPT) accepted as alternative route to vocational recognition |

Primary Source:
Wilde S. 25 Years Under the Microscope – A History of the RACGP Training Program. RACGP. 1998.

**What is the special professional expertise which distinguishes general practice from other areas of medical practice?**

A contemporary definition of a GP adapted from the RACGP's statement is:

> A doctor who has completed the FRACGP or has an equivalent qualification and who provides primary, continuing, comprehensive whole-person care to individuals, families and the community.

The distinguishing features are:

- Comprehensive repertoire of medical knowledge and skills for primary care
- Continuity of care
- First contact role
- Integration of biomedical and psycho-social perspectives
- Patient centred medicine – rather than disease centred
- Primacy of the patient-doctor relationship
- Recognition and management of seriously ill patients

- Recognition, early diagnosis and management of undifferentiated symptoms
- Understanding of gate-keeper and coordinating role
- Understanding of role in public health, health promotion and illness prevention
- Understanding their role in the context of the community and environment in which they work
- Whole-person care

McWhinney enunciated the following principles as guides to practice:

1. Commitment to the person rather than a particular body of knowledge or disease group
2. Understanding illness in terms of personal, family and social context
3. Every contact with patients is an opportunity for prevention of illness of health education
4. Commitment to thinking about health problems from a population perspective
5. Practising as part of a community-wide network of health and welfare support services
6. Living in, and being a visible and active member of the community in which they practice
7. Providing patient care at the practice, at the patient's home or at hospital
8. Being sensitive to the patient's and their own values, attitudes and feelings and the influence these have on the way they practice
9. Manage scarce health care resources for the maximum benefit of patients

Source: McWhinney I. A Textbook of Family Medicine. 1989

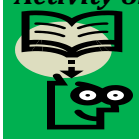
**What are the characteristics of general practice as a profession in the modern era?**

Reference to the literature suggests that the following characteristics are true of general practice contemporarily:

- Two groups of doctors exist: (1) GPs who mainly see unreferred patients with undifferentiated presentations, and (2) specialist doctors who mainly see patients on referral from GPs.
- General practice is seen as a legitimate specialist professional discipline
- Academic general practice/community medicine has become an accepted part of university medical schools
- GPs exercise a gate-keeper role which is seen as contributing to a more cost-effective use of health care resources compared to countries where this does not exist such as the USA.
- Primary care is in the ascendancy as it is seen that preventative and community based medicine is a more sustainable basis for health care than hospital based medicine.
- The role of the GP is broadening, eg. into management of chronic illness, stronger role in public health, more comprehensive primary care
- Nearly all GPs have been through profession-specific post-graduate vocational training
- Nearly all GPs have been assessed as competent for independent practice by passing professional college examination requirements (in Australia, the FRACGP, or very recently FACRRM)

- In Australia, Medicare provider numbers are largely restricted to doctors who have completed a recognised training program leading to the FRACGP, FACRRM or an equivalent.
- To maintain practice as GPs there are continuing quality assurance requirements

***Activity 8.9***



## *Evolving as a Profession*

After reflecting on the evolution of general practice and its current status what do you think are the main features of its professional status? Do you think that the listed characteristics of contemporary general practice are an accurate reflection of its status in medicine and the community?

Reflect on the development of GP training. What are the significant features you noted about this? How has the development of GP training contributed to general practice becoming more professional?

**WHAT THIS MODULE PROFESSES TO HAVE DONE**

## *Confess What you Profess!*

Use the following list to check off whether these things have worked for you:

You should:

- Have a clear understanding of why professionalism is important in the ME role
- Be more able to exercise a duty of care to those involved in GP training
- Have improved ability to demonstrate your commitment to general practice as a profession
- Be more able to reconcile different professional viewpoints
- Have greater awareness of the evolution of general practice as a profession
- Have a better understanding of how GP training has developed
- Be more self-aware of your own values and attitudes in exercising ME responsibilities

**If you agree that you have achieved these outcomes give yourself a tick or a hug.**

**If you disagree maybe you have some thoughts on how this module could be improved.**

**Whether you agreed or disagreed any feedback you have would be welcome.**

**You could post this feedback through AMEN's GPRime website.**

**TOOLS OF TRADE**

***Tool 8.1***

## *Scenario: Ethical Element Analysis*

**This tool enables you to analyse any given scenario or situation in terms of the Core Elements of Ethical Behaviour.**

**Write in a succinct description of the situation.**

**Then for each core element record how it is relevant to the situation and how you would meet this requirement.**

**DESCRIPTION OF SCENARIO/CASE/SITUATION**

| CORE ELEMENT OF ETHICAL BEHAVIOUR | HOW CORE ELEMENT IS RELEVANT AND HOW YOU WOULD MEET ITS REQUIREMENTS |
|---|---|
| **CLARIFICATION** | |
| **ALTERNATIVE PERSPECTIVES** | |
| **ANALYSIS** | |
| **JUSTIFICATION** | |
| **INTEGRITY** | |

*Tool 8.2*

## *My Ethical Framework Influences*

**This tool enables you to reflect on the aspects of your background and experience which have shaped your ethical framework.**

**It can be used as a basis for self-reflection on your ethical positions and values and to improve understanding of differing ethical perspectives.**

**For main aspect record how it has influenced your ethical perspective and the way you behave.**

| ASPECT | How this has influenced your ethical perspective and the way you behave. |
|---|---|
| FAMILY INFLUENCES | |
| INFLUENCE OF FRIENDS, PEERS | |
| RELIGION | |
| SCHOOLING | |
| CULTURAL INFLUENCES | |
| MEDICAL TRAINING | |
| SOCIO-ECONOMIC INFLUENCES | |
| IMPORTANT LIFE EVENTS | |
| OTHER FACTORS | |

*Tool 8.3*

## *ME Ethical Behaviour Self-Assessment Tool*

**This tool enables you to rate yourself on various dimensions of ethical behaviour.**

**Use a scale of: 1 = Very good through to 5 = Needs much improvement.**

| Aspect of Behaviour | Self-rating | Comment (Ways to improve) |
|---|---|---|
| Capacity to identify key elements of a situation or problem | | |
| Capacity to recognise different socio-cultural perspectives | | |
| Capacity to weigh up and balance different considerations in determining a course of action | | |
| Need for obedience cf your willingness to calculate possible benefits | | |
| The balance you strike between paternalism and client autonomy | | |
| Extent to which you will avoid or declare conflicts of interest | | |
| Attitude to truth telling – whole truth vs hedging or softening or white lying | | |
| The balance you strike between actively doing good cf. doing no harm | | |
| Commitment to client confidentiality and privacy | | |
| Commitment to ensuring fairness and equity in handling clients | | |
| Acceptance of client rights to get other opinions, complain and appeal | | |
| Recognition, willingness to work within, and admit your won limitations | | |