CONCEPTUALIZING AND OPERATIONALIZING HONESTY AND INTEGRITY IN POSTGRADUATE MEDICAL EDUCATION

By

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Abstract

The teaching and learning of professionalism is recognized as an important component of medical education in Canada at both the undergraduate and postgraduate level. The Royal College of Physicians and Surgeons of Canada has developed a competency framework which guides postgraduate specialty training in a number of areas including professionalism. This thesis draws upon qualitative interviews with Residency Program Directors in major Royal College specialties at medical schools in Canada, seeking to understand how respondents operationalize and conceptualize *honesty* and *integrity*, key components of professionalism as defined in Royal College documents. Findings indicate that honesty and integrity are seen as integral to professionalism, but are often difficult for Program Directors to define. Honesty is understood primarily as truth-telling, while integrity is seen as more as a trait of the individual. Uncertainty exists as to whether honesty and integrity can be taught and learned in residency, or whether they are immutable. Implications for the teaching and learning of professionalism in postgraduate medical education are explored.

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Chapter 1

Introduction

Medical education in the 21st century is both the inheritor of an ancient tradition of physician training and a thoroughly modern pedagogical enterprise shaped by contemporary technological, economic and societal forces. Medical schools, and the national organizations to which they belong, endeavour to educate professionals who are not only knowledgeable and technically skilled, but also in possession of attitudes and values responsive to the needs of the patients and populations they serve. Whether at the level of the individual or the profession, there is a call for exemplary, even idealized, conduct and character. The goals for educating and regulating physicians do not merely encompass ensuring an adequate level of competence, but also address attitudes, ethical standards, behavioral attributes, and moral values, a disparate set of aims sometimes grouped under the heading of "fostering professionalism".

In the last 25 years, the medical literature on professionalism has grown exponentially, medical schools have introduced curricula on professionalism, and the term has been incorporated into codes, charters, and accreditation standards (Hafferty & Castellani, 2010). Despite the substantial literature on professionalism, there is a lack of consensus among academics regarding what professionalism is, and how it is best taught and evaluated. As well, there are significant obstacles to knowledge transfer in medical education with postgraduate medical teaching taking place in a clinical setting, taught by practicing physicians who may not read the medical education literature on a regular basis. Practicing physicians adhere to a set of professional norms related to practice and

conduct, but they may have given little thought to the abstract and moral dimensions of professionalism. Just as diversity of opinion exists in the medical literature, there is likely to be considerable disagreement among physicians regarding what is considered professional behavior, with individual, generational, and cultural differences influencing opinion.

Program Directors, the physicians who administer the postgraduate medical programs for training resident physicians, are responsible for ensuring that their programs meet accreditation standards to teach and evaluate professionalism. However, they face many challenges. Even in teaching hospitals, medical faculty may lack familiarity with, or even actively resist, a curriculum which seeks to extend training requirements beyond the traditional body of medical knowledge and technical skills. In addition, the Program Directors themselves may lack a clear sense of what is meant by the contested term "professionalism".

Medical Education in Canada

To become fully qualified physicians in Canada, trainees must complete four years of undergraduate medical education (UGME) as medical students followed by postgraduate training (PGME) as residents. The first two years of UGME are predominantly didactic, with most of the learning taking place in classroom or small group settings. Curriculum during this period, commonly referred to as the preclinical years, includes such traditional subjects as anatomy, physiology, and biochemistry, as well as newer additions to the curriculum such as ethics and epidemiology. The last two years of UGME, referred to as "clerkship", take place predominantly in clinical settings,

particularly teaching hospitals, where the students spend set periods of time in rotations with different specialties such as family medicine, internal medicine, surgery, pediatrics, psychiatry, and obstetrics.

In the final year of UGME, medical students enter a centrally-coordinated matching service that pairs them, in a competitive fashion, with training programs in their specialty of choice, known as "residencies". Residency programs range in length from two years for family medicine to six years or more for specialty and subspecialty programs. Residency programs in Canada are overseen by the medical schools, with training taking place in an apprenticeship model at affiliated academic hospitals. The fact that the term "training" is frequently used to describe the teaching and learning that takes place at the PGME level (rather than the term "education" which is used more often in UGME) reflects the practical orientation of residency and its specificity to particular professional settings (Garavan, 1997).

Each school has a number of residency programs, with physician Program Directors appointed by the individual departments reporting to a Postgraduate Associate Dean at the medical school. Unlike UGME, which is predominantly administered through the medical school, responsibility for developing, administering and implementing the curriculum in PGME lies more with the clinical academic Departments associated with the medical school e.g. Department of Family Medicine, Department of Psychiatry. PGME is regulated by two professional bodies: the College of Family Physicians of Canada, which regulates education in family medicine, and the Royal College of Physicians and Surgeons of Canada (RCPSC) which is responsible for

specialty programs. In order to prepare residents to be eligible for the certifying exams, programs must adhere to the accreditation standards established by these bodies.

In setting out the requirements for specialty education in Canada, the Royal College uses a framework called the CanMEDS 2005 Physician Competency Framework. The history of how CanMEDS was developed by the Royal College in response to societal opinion regarding the role of physicians will be discussed in more detail below. The CanMEDS framework defines seven Roles that are seen as essential to the practice of medicine: Medical Expert, Communicator, Collaborator, Manager, Scholar, Health Advocate, and Professional (See Appendix I). Each of the CanMEDS Roles comprises a set of Competencies and Elements that contribute to the execution of this Role by physicians in daily practice (Competencies, Elements, and Roles are all capitalized in the CanMEDS documents).

The RCPSC has established general accreditation standards which state that each residency program "must ensure" that the CanMEDS Roles are being effectively taught and that the residents are being evaluated on their performance of the Roles (Royal College of Physicians and Surgeons, Accreditation Standards, revised 2012, p. 7). While the Roles are defined using Core Competencies and Elements, there is a great deal of subjectivity associated with the definitions. The individual Program Directors decide how the Roles will be taught and evaluated at their site.

The RCPSC defines professionalism as "those skills, attitudes and behaviors which we have come to expect from individuals during the practice of their profession... Maintenance of competence, ethical behavior, integrity, honesty, altruism, service to

others, adherence to professional codes, justice, respect for others, self-regulation, etc." (Frank, 2005, p. 10). Objectives for the Professional Role emphasize the engagement of physicians in ethical practice, profession-led regulation, and adhering to high personal standards of behaviour. (Appendix II)

To assist Program Directors, the Royal College provides training sessions and materials on how to teach and the CanMEDS Roles (Bandiera, Sherbino, & Frank, 2006). As well, there is a large and ever-growing body of medical education literature addressing both theoretical and practical questions of how professionalism should be defined, taught, and assessed. Given the apparent wealth of resources, it may seem surprising that Program Directors nonetheless report that they lack guidance in how to develop curriculum and evaluations strategies for the Professional Role (Snell, 2009) and report only moderate levels of satisfaction with its evaluation (Chou, Cole, McLaughlin, & Lockyer, 2008).

Research Study Background and Purpose

Perhaps more than any other CanMEDS Role, the Professional Role contains a number of terms that are highly conceptual and open to multiple interpretations. These include altruism, integrity, honesty, morality, compassion and caring (Frank, 2005). Given the difficulty in defining these terms, as well as questions regarding how (or whether) they can be taught and evaluated, Program Directors are asked to carry out a challenging task. With this in mind, it seemed timely and important to inquire of Program Directors in Canada regarding their teaching and evaluating the CanMEDS Professional Role.

As described in more detail below, the data for this thesis was collected through interviews carried out by myself and a colleague as part of a larger study supported by the Dalhousie Division of Medical Education's Program in Health and Medical Education Research (PHMER) and funded by the Royal College of Physicians and Surgeons of Canada. Our research team comprised generalist and specialist family physicians, medical education researchers, and other academics. The study design was a sequential mixed methods approach, with a Phase One quantitative on-line questionnaire followed by Phase Two qualitative interviews of program directors. A detailed description of the methodology of this study can be found in the chapter on methods.

The quantitative phase identified "Integrity and honesty" as key aspects of the Professional Role for Program Directors (note that in the definition of the Role, they are grouped together as one Element). However, questions remained as to how they understood these terms. The purpose of my research was to explore the following questions in the interviews with Program Directors: What is the role of "integrity and honesty" with respect to "professionalism" as taught in Canadian residency training programs? How can honesty and integrity be conceptualized and operationalized in the Postgraduate Medical Education context? And finally, do Program Directors believe honesty and integrity can be successfully taught to residents, or do they see them as immutable?

Chapter II

Literature Review

"Integrity and honesty" are listed together in the Elements of the CanMEDS Professional Role, and in the initial quantitative stage of our study, were identified by those surveyed as the single most important Element of the Role. However, as with many components of the CanMEDS framework there are no definitions provided for these terms, nor suggestions as to how they should be operationalized. Before considering how honesty and integrity relate to medical professionalism, it is important to consider how professionalism is currently understood within medicine, how this reflects the historical roots of the profession, and what methods of teaching and assessing professionalism currently exist. As teaching professionalism can be understood as integrally related to professional identity formation, I will also discuss what is known about how professional identity develops through socialization into the medical profession. Finally, given that the CanMEDS framework strongly influences the social-professional environments in which residency training takes place, I will provide some additional background on CanMEDS and the Professional Role before addressing honesty and integrity specifically.

Defining Professionalism

The Ontario Medical Association (OMA) defines professionalism as "a set of behaviours or characteristics that are attributed to physicians who are held in high esteem, or set an example for the profession" (OMA, 2011, p. 19). The OMA lists several characteristics that are "commonly associated with professionalism": integrity, respect,

civility, trustworthiness, responsibility, reliability, accountability, and altruism. However, this is only one possible definition for professionalism. There is no universally accepted definition or list of attributes, and instead the professionalism literature is marked by heterogeneity and contradiction. In addition, there has been a dramatic increase in the number of publications in the medical literature related to professionalism, with a 10-fold increase noted between 1991 – 1995 (28 articles published during this period) and 2001 – 2005 (273 articles published) (Rees & Knight, 2007). Cruess, Cruess and Steinart (2009) include an appendix in their book *Teaching Medical Professionalism* (2009) which lists over a dozen definitions of professionalism, some taken from dictionaries, others from the social sciences literature and the medical literature, and yet others produced by medical organizations and accrediting bodies (Cruess, Cruess & Steinart, 2009).

In an attempt to synthesize a definition of professionalism, Wilkinson, Wade, and Knock (2009) stated:

> Although there are many definitions of professionalism, these are often so broad that they do not lend themselves to aspects that are easily assessable. Furthermore, there is no agreed consensus, and views on professionalism may change over time. The existing definitions also lack a clear breakdown of the elements of professionalism into aspects that could be measured. (p. 552)

From their analysis, Wilkinson et al. (2009) identified five "clusters" of professionalism: "adherence to ethical practice principles; effective interactions with patients and with people who are important to those patients; effective interactions with

people working within the health system; reliability; and commitment to autonomous maintenance / improvement of competence in oneself, others, and systems." Subcomponents of the cluster "adherence to ethical practice principles" include honesty and integrity, confidentiality, moral reasoning, and respect for codes of conduct (p.556). Of the clusters, "adherence to ethical practice principles" has perhaps the greatest degree of resonance with the CanMEDS Professional Role, while others seem to overlap greatly with other CanMEDS Roles, such as Collaborator, Communicator, and Manager.

Some professionalism researchers have attempted to translate the goals and concepts associated with professionalism into observable behaviors. However, this approach may only serve to expose the lack of consensus that exists. For example, Green, Zick, and Makoul (2009) asked physicians, nurses, and patients to rate 68 behaviorally-based items in terms of their relevance to physician professionalism. They found high levels of agreement between on groups regarding the importance of certain items, especially, "Practices in an ethical manner" and, "Is honest". However, there was less agreement regarding certain other aspects of practice. For example, patients were much more likely than physicians or nurses to think that professional behavior on the part of physicians should include "Pays attention to the cleanliness and comfort of patient areas", while physicians and nurses rated the item, "Controls own emotions and maintains composure" more highly than did patients (Green, Zick, & Makoul, 2009). It should be noted that while the study asked respondents to indicate the importance of individual items, the items themselves were not operationalized. For example, while "Is honest" received a high level of endorsement, there was no description provided as to what behaviors an honest physician might exhibit. This study is useful because it

demonstrates how efforts to operationalize (and standardize) professionalism may expose subjectivity and disagreement. However, it also suggests that honesty and ethical practice are perceived as key elements of professionalism by patients as well as physicians.

Hafferty and Castellani (2010) avoid a normative approach to defining professionalism in terms of what it should be. Instead, they identify several competing types of professionalism which form a complex system operating at the micro level (individual), meso level (social interactions and relationships), and macro level (social movement). The three most dominant and visible types of professionalism according to their classification system are nostalgic professionalism (emphasizing altruism and interpersonal competence), entrepreneurial professionalism (emphasizing commercialism and technical competence) and lifestyle professionalism (emphasizing lifestyle and balance).

Another approach to making sense of the broad literature on professionalism was taken by the International Ottawa Conference Working Group on Professionalism (IOC-PWG) (Hodges et al., 2011). IOC-PWG consisted of a group of medical educators with recognized expertise on the topic of professionalism education. Members of the group identified key articles on the topic that were then subjected to critical discourse analysis. Professionalism discourses were classified by scope as being individual, interpersonal, or societal/institutional, and by and epistemology as objectivist/positivist or subjective/constructivist. Within the positivist literature, articles were further categorized as being generalizable or having limited generalizability based on whether professionalism was seen as being heavily influenced by context or more universally

applicable. The authors acknowledged that there is a strong conviction among many educators that an urgent need exists to produce "concrete and operationalizable definitions, and from them effective teaching methods and defensible assessment approaches across the continuum of professional development" (Hodges et al., p. 356). At the same time, they acknowledge the complexity of professionalism:

> Each perspective (and resulting assessment methods) will make some elements of professionalism visible, and each will deflect attention from other elements. Elements of professionalism are vast and include: individual (attributes, characteristics, attitudes, behaviours and identities), interpersonal (relations, group dynamics, etc.) and societal (economic, political, etc.). (p. 356)

Thus, there are different approaches to understanding professionalism. These include attempts to define it and operationalize it in concrete terms, but also perspectives that consider how definitions are constructed and what is gained or lost by viewing professionalism through competing or complementary lenses. Nonetheless, uncertainty about what constitutes professionalism has not prevented its inclusion in accreditation standards for medical education at the undergraduate and postgraduate level. While the discussion continues in the medical literature, practical considerations require those responsible for medical education to make decisions about curriculum that are actively influencing how professionalism is being taught and evaluated.

Historical and Current Context

How did professionalism come to be a focus of attention in medical education at the beginning of the twenty-first century? It is important to understand that current

controversies about professionalism arise from both historical context and current societal pressures. While the history of medicine dates back to antiquity, the professionalization of medicine is a relatively recent historical development. Prior to the twentieth century, medical training was not standardized, and there was little regulatory oversight. As a result, there was considerable variability in the skills and credentials of those who identified themselves as physicians, with private, for-profit schools producing large numbers of doctors with only a minimal amount of training (Duffy, 2011). It was not until the Flexner Report of 1910 that medical training in North America took its current form, with the requirement of a premedical degree, the two years of preclinical instruction in anatomy and basic sciences, and a two-year clinical clerkship taking place primarily in the setting of the teaching hospital. The Flexner Report, written 100 years ago, has been called the "professionalism project" of the early 20th century (Hafferty & Castellani, 2010).

Abraham Flexner was an educator hired by the Carnegie Foundation in partnership with the American Medical Association to prepare a report on North American medical schools. He subsequently made a number of recommendations in his report, *Bulletin Number Four, Medical Education in the United States and Canada*, also known as the Flexner Report (Flexner, 1910) which included the requirement of an undergraduate degree prior to medical training. Flexner was influenced by John Dewey's belief in problem-solving and experiential learning rather than rote memorization (Dewey, 1938), and he believed that studying science would not only provide students with knowledge about the biological underpinnings of disease, but would also foster a scientific approach to the practice of medicine. Therefore, he proposed the addition of

two years of didactic teaching in basic science to the medical curriculum. Flexner was also interested in professional identity formation. He believed that exposure to scientifically-oriented physicians was important in order to encourage learners to adopt the scholarly values and approaches he saw as important for doctors (Irby, Cooke, & O'Brien, 2010). Following the preclinical years, medical students would complete a two-year supervised clinical experience, seeing patients in teaching hospitals and being supervised by physician-scientists who divided their time between research and clinical patient care (Duffy, 2011; Cooke, Irby, & O'Brien, 2010).

Flexner's report was very influential, and within a short period of time his recommendations were widely incorporated in the medical school curriculum and licensing requirements (Duffy, 2011). In response to criticisms made in the Flexner report, a number of medical schools were closed due to substandard educational practices (unfortunately including some that had offered rare training opportunities for women and African-Americans). Although Flexner is commonly credited with the development of the modern North American medical school, many of his ideas corresponded with those already held by his physician colleagues, who may have considered it expedient to have the recommendations for change come from a non-physician. As Duffy (2011) puts it:

> An unflattering but not necessarily inaccurate description for Flexner's assignment was that he was to be the hatchet man in sweeping clean the medical system of substandard medical schools that were flooding the nation with poorly trained physicians. (p. 271)

As training became more regulated, it also became more specialized. A dramatic increase in the number of specialty programs in the United States took place in the 1930's and 1940's (Cooke et al., 2010). In Canada, the Royal College of Physicians and Surgeons of Canada (RCPSC) was established by the federal government in June 1929 to oversee postgraduate medical education (PGME). Initially, the only specialties recognized by the Royal College were in general medicine and general surgery. Over time, as specialties proliferated, the number grew to the present 29 specialties and 35 subspecialties (Royal College History and Heritage, n.d.).

In the one hundred years since Flexner, the scientific model of medicine led to many discoveries and advances in areas such as human genetics, pharmacology and therapeutics, diagnostic imaging, surgical techniques, and public health to name just a few (Lyons & Petrucelli, 1987). However, the scientific model has also been criticized by those who believe medicine has lost its humanistic and moral values (Shapiro & Rucker, 2003). Even during Flexner's time, Sir William Osler, a prominent Canadian physician, argued that bedside teaching was more central to the role of the physician than laboratory or scientific training. In recent decades, there has been increasing concern that the model espoused by Flexner may carry the risk of objectifying patients as subjects of scientific investigation rather than persons in need of healing. Many of the innovations in medical education today, including those which attempt to define or teach professionalism to students, can be seen as an attempt to counterbalance the scientific influence of Flexner with a more caring, patient-centered approach (Duffy, 2011).

Another major trend within medical education in recent years, and one having significant implications for how training is organized and delivered in both UGME and

PGME, is the widespread adoption of competency-based medical education (CBME). In CBME, physician competence is conceived as comprising multiple domains that extend beyond medical knowledge and procedural skills to include non-traditional areas such as communication and systems-based practice. According to the CBME model, physician competence consists of intersecting and interacting competencies, which can themselves be broken down into smaller elements. CBME seeks to identify desired outcomes that correspond to behaviors taken by physicians in practice, and then to design curricula that will help trainees achieve these (Taber, Frank, Harris, Glasgow, Iobst & Talbot, 2010).

CBME has been described as inherently utilitarian, differing from the traditional curriculum in requiring that material being taught to learners must be directly aligned with what will be needed in practice (Frank et al., 2010; Taber et al., 2010). While it might seem self-evident that medical education should be designed according to what doctors do in practice, it in fact represents a significant shift. For example, trying to determine what basic scientific knowledge is actually required of practicing physicians poses a challenge to those teaching the traditional preclinical curriculum, which has been weighted toward basic sciences like anatomy and biochemistry since the time of the Flexner Report. The decline in total hours dedicated to anatomy in the medical school curriculum (Drake, McBride, Lachman & Pawlina, 2009) is one example of how CBME is changing medical education.

CBME has systemic implications that pose novel challenges to medical schools. Significantly, CBME opens the possibility of moving away from time-based training programs, allowing students to complete their course in a shorter or longer time if they are able to demonstrate that they have acquired competency. This would be a marked

change from the current practice of training for set periods of time (four years of medical school, five years for specialty training). Implementing such a system would require a high degree of individualization of schedules and could also require an intensification of resources at sites where 'bottlenecks' would occur (Taber et al., 2010).

CBME requires high-quality, ongoing, criterion-based evaluation of learners in order to be effective. Because it influences both the training experience and the clinical standards, the clinical setting should be one that is recognized as meeting standards appropriate for training. The adoption of standardized assessment tools is also advocated (Holmboe, Sherbino, Long, Swing & Frank, 2010). However, it may be difficult to evaluate certain competencies in a criterion-based or standardized manner, especially non-traditional ones such as communication, collaboration, and professionalism.

Other potential challenges exist. There is the possibility of breaking down competencies into discrete components that can be assessed using objective means, but at the same time losing an overall global impression of ability that may be more useful or accurate (Huddle & Heudebert, 2007). It has been suggested that CBME promotes the attainment of minimum standards rather than excellence. Implementing CBME requires faculty development, followed by an ongoing need for faculty resources so that learners can be adequately observed in a clinical setting, evaluated, and provided with feedback (Frank et al., 2010). As accreditation standards have changed to reflect principles of CBME, it seems likely that training programs are running an adapted CBME model incorporating certain aspects and not others. For example, while Canadian residency training programs have had to implement outcomes-based training objectives in order to

meet accreditation standards, the flexible time requirements implicit in the model have yet to be widely adopted.

Nonetheless, CBME has many advantages, and makes sense on an intuitive level. In North America, CBME has come to define the way physicians attain and maintain professional accreditation (Hodges, 2010). In the United States, the Accreditation Council for Graduate Medical Education (ACGME), which oversees postgraduate training, has set six core competencies for residents. In Canada, the Royal College of Physicians and Surgeons of Canada (RCPSC) developed the CanMEDS framework to define outcomes in CBME. The CanMEDS framework has achieved international recognition, and has been incorporated into specialist training in the UK, the Netherlands, Denmark, Australia, New Zealand, and the USA (Chou et al., 2008). The College of Family Physicians of Canada has adapted the model for use in family medicine, and many (although not all) Canadian medical schools use it to define outcomes in UGME. The RCPSC also uses the CanMEDS framework in its Maintenance of Competence (MOCOMP) program for specialists in practice. Thus, CanMEDS has influence along the continuum of medical education in Canada, with its effect being felt at the individual and institutional level.

The predecessor of the CanMEDS framework was an earlier roles framework, Educating Future Physicians of Ontario (EFPO). EFPO arose out of the Ontario physicians' strike of 1986, when medical educators identified a need to redesign medical training so that graduates would be better prepared to meet the needs of society. From this, a project of public and professional consultation was undertaken which led to the elucidation of specific "roles". This was a complex process, and as Whitehead, Austin

and Hodges (2011) state, "such discussions, negotiations, and re-working of the roles highlight the socially constructed nature of roles definitions" (p. 688).

As defined by the Royal College of Physicians and Surgeons of Canada, the CanMEDS Roles are; Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional. (RCPSC) These Roles are considered overlapping, and the visual representation of CanMEDS takes the form of a flower, often referred to as the "CanMEDS daisy". At the center of the daisy is the Medical Expert Role, with the other Roles encircling the middle (see Appendix I). In defining the Medical Expert Role, RCPSC documents (Frank, 2005) state:

> As Medical Experts, physicians integrate all of the CanMEDS Roles, applying medical knowledge, clinical skills, and professional attitudes in their provision of patient-centered care. Medical Expert is the central physician Role in the CanMEDS framework. (p. 1)

Thus, the traditional role of the physician as holder of medical knowledge and expertise, is considered to be central or defining in this model, while the non-traditional elements such as professionalism or communication (sometimes referred to as 'non-Expert Roles), although still essential, are presented as peripheral. This is not to say that there have not been advances in how medical expertise is taught: the increasing complexity of medical knowledge and the easy accessibility of information through technological means have led to an emphasis on teaching medical students how to effectively access and manage information in the clinical setting, rather than committing facts to memory (Sierles, 2010), and given the rapid growth of knowledge, promoting a

'habit of mind' that fosters life-long learning is seen as a key goal of medical education (Irby, Cook, & O'Brien, 2010). Nonetheless, there is a higher comfort level with the Medical Expert Role in PGME than with the other CanMEDS Roles. In a study of Canadian Program Directors, Chou et al. (2008) found the high levels of satisfaction with the evaluation of the Medical Expert Role. Program Directors had lower levels of satisfaction with evaluating the other Roles, with Health Advocate and Manager scoring the lowest (Chou et al., 2008). Limitations to teaching the Roles identified by PDs include faculty acceptance, lack of confidence in expertise, and time limitations (Whitehead, Martin, Fernandez, Younker, Kouz, Frank & Boucher, 2011).

The CanMEDS Professional Role has three Key Competencies, 14 Enabling Competencies, and 17 Elements. (Appendix II) The description of the Professional Role as it appears in CanMEDS documents (Frank, 2005) states:

> As Professionals, physicians are committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behaviour…. As such, the Professional Role is guided by codes of ethics and a commitment to clinical competence, the embracing of appropriate attitudes and behaviors, integrity, altruism, personal well-being, and to the promotion of the public good within their domain. These commitments form the basis of a social contract between a physician and society. Society, in return, grants physicians the privilege of profession-led regulation with the understanding that they are accountable to those served. (p. 10)

Thus, the Professional Role comprises individual characteristics, moral values, and regulatory/institutional realities. Despite materials from the RCPSC and a large body of literature addressing the defining, teaching, and assessing of professionalism, Canadian program directors (PDs) report that they have little to guide them in developing and implementing curricula for the Professional Role (Snell, 2009). In the study of Program Directors by Chou, the mean satisfaction score for the CanMEDS Professional Role was 3.41 on a 5 point Likert scale, where 4 was 'satisfied' and 3 was 'neutral', indicating that on average Program Directors were not particularly satisfied with the evaluation of the Professional Role in their programs (Chou et al., 2008).

Thus, medical education since the time of Flexner has shifted its goals away from developing physician scientists are who are primarily medical experts, and now aims to educate physicians who are skilled in a wide range of areas not included in the traditional model. Recently, the Carnegie Foundation for the Advancement of Teaching (CAFT) published *Educating Physicians: A call for reform of medical school and residency* by Molly Cooke, David Irby and Bridget O'Brien, released on the centenary of Flexner's report. CAFT's report recommends four goals for medical education: 1) standardize outcomes while individualizing the learning process, 2) integrate formal knowledge and clinical experience, 3) develop habits of inquiry and innovation, and, 4) focus on identity formation (Cooke, Irby, and O'Brien, 2010). As Hodges (2010) points out, "Unlike the reforms that Flexner envisioned to bolster the scientific basis of medicine, the reforms proposed today are about context, culture, and professional socialization" (p. S36). In particular, the process of professional identity formation is linked to teaching

professionalism, as medical educators seek to determine how best to foster development of a professional identity that is appropriate for practice in the twenty-first century.

Thus, there have been a number of ideological shifts within medical education that have led to an increased emphasis upon education for professionalism. However, medical education, and in particular PGME, occurs outside the classroom, and is strongly influenced by both society at large and the medical subculture. Thus, changes within the milieu where residency education takes place may be very influential in determining the values of the learners and the profession in general. In the past 25 years or so, there have been shifts in the demographics of medicine that have influenced the work environment. While the causative role is not established, the growing presence of women and observed generational differences in values and priorities appear to coincide with regulations limiting work hours for physicians and an increased focus on life outside of work. As well, increased cultural diversity within society is mirrored by changes in the physician workforce. At the same time that opinions and approaches in the medical education literature are evolving, students are changing, and so are the faculty of the teaching hospitals. It is worthwhile considering how this may be contributing to the dialogue regarding what constitutes medical professionalism.

According to the Canadian Medical Association, 33% of physicians practicing in Canada in 2009 were women, and the number is expected to continue to rise (CMA, 2009). Women currently outnumber men in Canadian medical schools (Palepu & Herbert, 2002). In 2006, 27.8% of physicians were female compared to only 7.6% in 1970 (American Medical Association, 2009). In addition to having different values with regard to medical practice, studies have shown that women physicians work fewer hours

and are more likely to take time off for child-rearing (Levinson & Lurie, 2004). Perhaps even more significant is the generational shift that is occurring. Jean Twenge has used the term 'Generation Me' to refer to the demographic group who were born after 1970. They may request special consideration or accommodation from their teachers, and may seek jobs that allow for increased leisure time (Twenge, 2009). Generational differences are perhaps most striking in the area of work hours. In recent years, contracts have limited the number of hours that residents and medical students are required to work consecutively. Professionalism as a construct has been recruited to both sides of the debate, with one side promoting altruistic self-sacrifice and claiming that accommodating the personal needs of the physician over patient care is unprofessional, while the other side argues that to be truly professional the physician needs to attend to his or her own wellness to the same degree as that of his or her patients (Peets & Ayas, 2012). The need to foster common professional values that will resonate with both younger and older physicians is one of the most pressing practical challenges facing the professionalism education movement at the beginning of the twenty-first century (Johnson & Peacock, 2009).

Another significant change in the physician workforce is increased ethnic and cultural diversity, partly due to the increasing diversity of the Canadian population, but also related to the high proportion of physicians who receive at least part of their training outside of Canada. International medical graduates (IMGs) are frequently granted licenses to practice in underserviced, often rural, areas that have difficulty attracting Canadian graduates. In 2005, over half of the physicians in Newfoundland and Saskatchewan were fully or provisionally licensed IMG's (Audas, Ross & Vardy, 2005).

The largest proportions of IMGs are to be found in the United States, the United Kingdom, Australia, and Canada, where IMGs comprise 23 -28% of the physician workforce (Wong & Lohfeld, 2008). It has been speculated that increasing diversity in the medical field may be one contributor to changes in the culture of medical professionalism in Canada due to differing perspectives on what constitutes appropriate behaviors, relationships, and ethical judgements (Ontario Medical Association, 2011). In addition to the practical challenges associated with moving to a new country and obtaining licensure, IMGs may experience loss of professional identity or professional role confusion due to cultural difference regarding roles and responsibilities, interprofessional practice, doctor-patient relationships, and ethical issues. Sufficient time in training, with support from medical peers and mentors, appears to be important for IMGs to successfully adapt to Canadian cultural and professional norms (Wong & Lohfeld, 2008).

In summary, the current climate of medical education is one in which a number of pressures are being exerted upon residency programs both from within and without. Program Directors in PGME are being asked to move beyond their historical mandates to prepare physicians who are 'medical experts' and to take on the responsibility for fostering such diverse competencies as communication, advocacy, and management. Of the 'non- medical expert' competencies, professionalism is among the most challenging, and as will be discussed, deciding how it should be taught and assessed pose significant difficulties for educators.

Teaching and Assessing Professionalism

Teaching professionalism and assessing professionalism, while clearly related, are also quite different tasks for Program Directors and medical educators. Shephard (2000) writes about the disconnection that exists in the field of education between paradigms of curriculum and instruction, which draw upon constructivism, and evaluation, which is strongly positivist in orientation. The same tension exists within the medical education literature, especially with regard to abstract entities such as professionalism.

There are many approaches to teaching professionalism described in the literature, and considerable variation exists not only in what is taught but how it is taught. While some incorporate didactic components, it is generally agreed that an experiential component is essential (Riley & Kumar, 2012). A 2012 Association for Medical Education in Europe (AMEE) guide on teaching professionalism provides a general framework for integrating professionalism into the curriculum which includes agreeing upon an institutional definition of professionalism, integrating learning across all years, organizing the curriculum using learning models (such as reflection and situated learning), recognizing the influence of the formal, informal and hidden curricula, and assessing the effects of the curriculum (O'Sullivan, Van Mook, Fewtrall & Wass, 2012).

Researchers studying professionalism often focus on how it is perceived by students and faculty and attempt to identify factors that support or hinder the teaching of professionalism. In one Canadian example, focus groups with medical faculty (primarily drawn from psychiatry and surgery) were conducted at University of Toronto to determine how they defined professionalism and what factors supported or undermined

the teaching of professionalism to medical students and residents. The authors found that professionalism was perceived as being difficult to define, often locally constructed according to values and norms of the clinical setting in which it occurred. Stressful situations, such as being on call, were thought to lead to increased unprofessional behavior. A distinction was made between minor lapses in professionalism, which were seen as more likely to be contextual and amenable to education and remediation as opposed to more serious lapses which were perceived as being related to an individual's character or personality and possibly not remediable. There was a suggestion that professionalism might differ between medical specialties, with what constitutes professional or unprofessional behavior in the operating room being different from how it would be viewed by non-surgical specialties. There was a perception among those studied that role modelling and clinical learning were of primary importance, and that this was more influential than didactic teaching about professionalism. A major theme was the persistence of unprofessional behavior and a perceived institutional tolerance that led to unprofessional behavior by faculty that was then modelled by residents and other learners (Bryden, Ginsburg, Kurabi & Ahmed, 2010).

This study exemplifies the importance of relating professionalism education to the clinical environment in which learners practice. Situated learning and related concepts such as narrative and role modelling provide useful theoretical perspectives for developing strategies to encourage the integration of theory and practice. Situated learning is based upon the idea that knowledge is contextually situated and influenced by culture. Key components of situated learning include cognitive apprenticeship, collaborative learning, reflection, practice, and articulation of learning skills. In the

situated learning model, the learner gradually takes on a more responsible role as time passes and experience is gained (Steinert, 2009). Situated learning is an educational approach or philosophy that can be adapted to a variety of educational goals including professionalism. Situated learning recognizes that professionalism draws upon tacit knowledge (Lave & Wenger, 1991; Eraut, 2000). Tacit knowledge is implicit rather than explicit, and arises from the cumulative effects of experience. In defining what professionalism 'looks like', educators draw on tacit knowledge that includes their personal definitions of moral terms associated with professionalism, such as honesty and integrity.

Narrative has been described as an essential part of situated learning, facilitating the social construction of knowledge and acting as a means of organizing and storing information. The development of narrative competence has also been proposed as means of teaching empathy (Steinert, 2009). Narrative approaches to teaching professionalism have been effectively employed, either on their own or as part of another pedagogical framework. Narratives used in teaching may be actual clinical narratives, or fictional narratives, but it is their connection to the real-life experiences of the students in order to be effective (Goldstein, Maestas, Fryer-Edwards, Wenrich, AmiesOelschlager, Baernstein & Kimball, 2006). Storytelling has also been proposed as a means of evaluating student professionalism through exploring behavioural explanations (Rees & Knight, 2007). While reflection is often incorporated into narrative medical education in a general way, some educators may also choose to focus on skills to facilitate professional behaviors, such as maintaining appropriate boundaries with patients (Gaufberg, Baumer, Hinrichs & Krupat, 2008). However, the most influential use of

narrative, either as an explicit educational practice or as a component of situated learning, may be in the formation of professional identity. Quaintance, Arnold and Thompson (2010) designed an intervention whereby medical students interview staff physicians about professionalism, specifically asking for positive examples and not negative ones. The students translated these into narratives which provided material for reflection. The goal of reflection was to generate new perspectives, reinforce professional values, and instill a commitment to professional behavior, as well as strengthening relationships between students and faculty (Quaintance, Arnold & Thompson, 2010). The relationship between socialization, identity, and narrative will be discussed in more detail in a later section.

One observation that occurs repeatedly within the medical education literature is that role modelling is of central importance in teaching professionalism. Role modelling is one component of social learning as described by Albert Bandura, along with imitation and identification. In role modelling, the teacher or role model behaves in a particular manner that the learner is then supposed to imitate, while at the same time selectively inhibiting previously acquired behaviors (Knowles, 1978).

Park, Woodrow, Reznick, Beales, and MacRae (2010) conducted semi-structured interviews with faculty members and residents in two Canadian surgery programs to explore what aspects of the role-modeling process were seen as most influential. Respondents identified four major sources from which professionalism was learned: personal values and upbringing, professional role models, the residency structure, and formal teaching. Of these, role models were seen as most important. Participants reported being influenced most strongly by positive role models, although negative role

models also served a purpose in demonstrating what not to do. The influence of parents and childhood upbringing was seen as important in forming the values and attitudes residents brought with them to professional training, but socialization into department's culture and developing a professional identity was also seen as relevant. The impact of formal instruction was less clear. In terms of how subjects understood the process of role modelling, observation was mentioned most often, although there was also some recognition of the role of reflection. The authors recommended that role modeling should be made more intentional and explicit by means of structured reflective self-examination and timely feedback. The use of specific strategies, such as portfolios, critical incidents, or disciplinary reports, was not mentioned (Park, Woodrow, Reznick, Beales & MacRae, 2010).

Similarly, a study of preclinical medical students found that even at an early stage of training, role modelling was seen to be of key importance. On the other hand, didactic teaching about professionalism was perceived much more negatively by the students, who described feeling "insulted" and even "victimized" by the professionalism curriculum (Baernstein et al., 2009). As well as supporting the value of role modelling, this study also provides a useful reminder that the approach to teaching professionalism must be carefully considered so as to not provoke resistance.

While role modeling may be an effective method of teaching (and learning) professionalism, concerns regarding the state of professionalism in medicine suggest that it is not simply enough to assume effective role modelling will occur. The challenge is that positive professional behaviors may not always be modeled: unprofessional behaviors can also be observed in clinical settings. Further, it is insufficient to consider

the role model/mentor and student exist as a dyad independent of the social networks in which they both operate (Haggerty & Castellani, 2010). The culture of the institution should foster professional behavior, and faculty members should be familiar with the concept of professionalism as it relates to medical education and be able to implement pedagogical strategies for teaching professional behavior. As the majority of assessment and evaluation takes place in a clinical setting, it is also important that faculty are capable of recognizing what constitutes professional behavior, and addressing unprofessional behavior effectively. Comprehensive professionalism promotion efforts may integrate instruction for learners and faculty development (Steinert, Cruess, Cruess, Boudreau & Fuks, 2007). Educational initiatives must be complemented by an aggressive effort to promote an institutional culture of professionalism, as the 'hidden curriculum' regarding what constitutes appropriate behavior for physicians has the power to negate what is officially included in the curriculum (Goldstein et al., 2006).

The question of how professionalism should be taught is closely related to the question of how it should be evaluated. The International Ottawa Conference Working Group on the Assessment of Professionalism (IOC-PWG) pointed out that there are a large number of tools for assessing professionalism described in the literature (over 80 in total), most of which have been developed to meet the needs of a particular program or local context. Methods of assessment are necessarily influenced by how professionalism is conceptualized, but generally focus on the individual and use observable behaviors as a proxy for professionalism as a construct. The authors suggest that multiple observations made over a period of time by different observers should be triangulated when assessing professionalism. In order for assessment to be meaningful and useful it should be

formative as well as summative, should be provided in a safe environment with effective mechanisms for feedback and follow up. The authors also emphasize the role of faculty development in assessment of professionalism (Hodges et al., 2011). A study of Canadian Program Directors using the CanMEDS Competency Framework found that the most commonly used method of evaluating the Professional Role was the In-Training Evaluation Report (ITER), which is used by supervisors to evaluate performance in a clinical setting (Chou et al., 2008).

Assessment of professionalism is usually based upon the observation of certain target behaviors. But some have argued that only considering behavior is inadequate; that trainees should not be evaluated simply upon how they behave, but rather on how they understand and justify their behaviors. This requires a capacity to recognize one's own values as well as the normative values of society, identify moral conflicts, and come to a decision that can be understood and explained rationally. Such an approach requires students to demonstrate a capacity for reflection as well as the ability to fulfill behavioral norms that are considered to be professional (Verkerk, de Bree & Mourits, 2007). However, the relationship between attitudes and behaviors is complex. Research suggests that an individual's attitudes may account for less than 10% of the variance in behavior in situations where there are strong social pressures or barriers to executing a particular behavior. Thus, local social norms may be more influential on professional behavior than the individual's beliefs or capacity for reflection (Rees & Knight, 2007).

In order to assist Program Directors who assess the CanMEDS Roles, including the Professional Role, the Royal College has published *The CanMEDS Assessment Tools Handbook: An introductory guide to assessment methods for the CanMEDS*

Competencies (Bandiera, Sherbino & Frank, 2006). This publication describes commonly used assessment tools including written tests (multiple choice and short answer questions), essays, oral exams, direct observation and in-training evaluation reports (ITERs), observed structured clinical examinations (OSCEs), multisource feedback, portfolios, and simulation. Of these, the tools considered most appropriate for evaluating the Professional Role are the ITER, multisource feedback, and portfolios. Written tests, essays, oral exams, and OSCEs are seen as less appropriate. This emphasis on evaluation of clinical performance rather than testing knowledge is in keeping with the idea that professionalism occurs through situated learning which is best evaluated based on performance in situ.

Perhaps the most challenging aspect of evaluating professionalism is identifying and remediating students who exhibit a pattern of lapses in professionalism (Papadakis, Loeser & Healy, 2001). While remediation can be broadly framed as education, there can also be a disciplinary component to remediation of professionalism that does not play as significant a role in remediation knowledge deficits, as lapses in professionalism could potentially include dishonest or unethical behaviors (Buchanan, Stallworth, Christy, Garfunkel & Hanson, 2012). As discussed below, medical professionalism is intimately associated with morality, and problems related to teaching professionalism may arise because of the difficulty in knowing how (and when) morality is learned.

Moral Dimensions of Professionalism

The assumption that the practice of medicine is a moral endeavour underlies most definitions of professionalism (Cruess, Cruess, & Steinart, 2009). Some authors have

advocated using the term ‘professional values’ rather than professionalism, especially when teaching students who may have a negative response to the latter term (Goldstein et al., 2006). Among the moral and ethical values included in the Professional Role are *Altruism, Integrity and honesty, Compassion and caring,* and *Morality and codes of behaviour* (Frank, 2005). Of these, altruism has traditionally been considered to be a core aspect of medical professionalism (Ludmerer, 1999). The term first appeared in English in the mid-nineteenth century. Abraham Flexner, author of the Flexner Report of 1910, viewed altruism, particularly as opposed to commercialism in medicine, as a key value to shape the profession of medicine (Hafferty & Castellani, 2010). While the CMA Code of Ethics does not use the term ‘altruism’, the first requirement listed under “Fundamental Responsibilities” is “Consider first the well-being of the patient”, a phrase that resonates with the ideals of Flexner and his contemporaries (CMA, 2004).

However, despite the fact that the term ‘altruism’ appears frequently in the medical education literature, the concept itself has been criticized as inappropriate for inclusion in training standards (Bishop & Rees, 2007). The Oxford Dictionary defines altruism as “disinterested and selfless concern for the well-being of others” (http://oxforddictionaries.com). Burks and Kobus (2012) point out that the use of the term in medicine is problematic because

> …Engaging in a professional, albeit helping, career in order to generate a source of income (which is inherently egoistic or self-directed) nullifies the possibility that such work or career roles might be considered as altruistic (which implies self-sacrifice for the welfare of others). Thus, in remaining true to the concept of altruism, an individual would not be able to perform an altruistic act for the

> purpose of attaining quid pro quo rewards or a salary because altruism necessitates self-sacrifice rather than self-benefit. (p. 318)

Burks and Kobus warn that actively promoting the importance of altruism in medicine may lead to cynicism and confusion. They suggest that more appropriate goals for medical education would be to develop learners' capacity for empathy and to encourage pro-social behaviors through "humanistic curricula". They also believe that promoting physician self-care and well-being are effective in combatting physician burnout, which has been associated in declines in empathy and altruism (Burks and Kobus, 2012).

However, it should be pointed out that for many authors writing about professionalism, altruism remains central in the value systems of medicine and a fundamental tenet of the "social contract" between medicine and society (Cruess et al., 2009). This belief is characteristic of Hafferty's "nostalgic professionalism" which draws its principles from the historical roots of professionalism (Hafferty, 2009). Altruism has also been identified as a moral duty associated with being a physician. Gert (2004) wrote about moral *rules* and moral *ideals*. Moral rules prohibit harming others either directly or indirectly (such as through dishonesty), while moral ideals promote altruistic acts such as helping others. The difference between the two is that while moral rules must be followed, it is not necessary to conform to moral ideals, although they can be positive influences on behavior (Gert, 2004). Alexandra and Miller (2009) argue that altruism in medicine goes beyond moral idealism because of what they call "professional role morality". Physicians have moral duties as part of their professional role, and "they should preserve the tradition because it embodies the moral duties that doctors have"

(Alexandra & Miller, 2009). The relationship between identity and moral obligation is discussed in more detail below.

While the CanMEDS Element *Altruism* has a particular historical association with the profession of medicine, *Integrity and honesty*, while important in medicine, have a broader applicability as traits that are important across a variety of settings. Compared to altruism, there is less debate about whether honesty and integrity are important in medical professionalism. *The Merriam-Webster Dictionary* defines honesty as "fairness and straightforwardness of conduct", or as "adherence to the facts: sincerity." Integrity is defined as "firm adherence to a code of especially moral or artistic values: incorruptibility" (Merriam Webster, n.d.). The Oxford English dictionary defines honesty as: "Uprightness of disposition and conduct; integrity, truthfulness, straightforwardness: the quality opposed to lying, cheating, or stealing". Integrity is defined as: "Soundness of moral principle; the character of uncorrupted virtue, esp. in relation to truth and fair dealing; uprightness, honesty, sincerity." Integrity also has a slightly different meaning that relates to the quality of wholeness or completeness (http://www.oed.com.ezproxy.library.dal.ca).

These dictionary entries emphasize the inter-relatedness of the two terms, with each word appearing in the definition of the other. Truthfulness appears to be an important related concept, as is adherence to a particular moral and behavioral standard. In their book *Teaching Professionalism* (2009), Sylvia and Richard Cruess define a number of attributes of medical professionals. In this list, as in the CanMEDS documents, 'Integrity and Honesty' are combined together as a single attribute, and then defined as follows: "Firm adherence to a code of moral values; incorruptibility" (Cruess

& Cruess, 2009, p. 15). Other attributes on their list which have a moral aspect include "Altruism", which is defined as "the unselfish regards for, or devotion to, the welfare of other; placing the needs of the patient before one's interest", "Caring and compassion" and "Moral and ethical conduct" (Cruess & Cruess, 2009, p. 15).

Given the value-laden nature of professionalism, it is important to consider how values come to be defined and shared by a particular group. Approaches to teaching moral values often emphasize the interrelated processes of 'practicing and becoming' (Bishop & Rees, 2007, p. 397). One useful perspective for medical educators is to view teaching of the moral aspects of professionalism as part of instilling within the learner a professional identity with its associated moral demands. To understand how this might be encouraged, it is important to consider what is meant by identity, and how the formation of physicians' professional identity arises from socialization within the medical teaching environment.

Identity and Secondary Socialization

Identity refers to an individual's self-concept, a complex, fluid construct that has both psychological and social origins. Examples of identities include those within family structures such as 'son' or 'wife', ethnic or gender identities, and professional identities such as 'doctor' or 'psychiatrist.' Identity as an individual or member of a group can influence beliefs and actions. Much of this self-conceptualization is formed through experience. When experiences occur in an interpersonal context, especially within a community, the process is one of socialization. Both primary socialization (occurring at

an early age) and secondary socialization (occurring in adulthood) can influence identity formation.

Individuals have a diverse range of identities available with which to ally themselves at any given time. A person may integrate more than one identity simultaneously, with some identities being 'nested' inside one another (a psychiatrist is a type of doctor) and others coexisting as relative constants (ascribed gender and ethnicity do not generally change over time as other identities are assumed). At different points in time, particular identities become more salient (determine self-perception and behavior to a greater degree) based on how relevant they are to the individual and to the context in which he or she is situated (Burford, 2012). We can understand the Self as not only the temperament, preferences and experiences of the individual, but the various identities he or she assumes (or is forced to assume), in combinations and permutations that will vary over time.

During medical education, physicians adopt professional identities that influence how they interact with patients and colleagues in the health care contexts (Beagan, 2004). For many, the influence of professional identity extends outside of regular clinical hours into social and personal spheres. One way of defining professionalism is as those behaviors and attitudes that arise out of the professional identity of the physician. The professional identity, or professional role, is influenced by external norms yet allows for considerable individual determination. Schon (1983) puts it this way:

> A professional role places skeletal demands on a practitioner's behavior, but within these constraints, each individual develops his own way of framing his

> role. Whether he chooses his role frame from the profession's repertoire, or fashions it for himself, his professional knowledge takes on the character of a system. The problems he sets, the strategies he employs, and the facts he treats as relevant, and his interpersonal theories of action are bound up with his way of framing his role. (p. 210)

Because identities exist within social contexts and fulfill particular social roles and functions, assuming a particular identity automatically engages the individual in a network of value-laden interactions and obligations. Regarding the self in social settings, Erving Goffman wrote, "society is organized on the principle that any individual who possesses certain social characteristics has a moral right to expect that others will value and treat him in an appropriate way" (Goffman, 1959, p. 112). At the same time, as Kwame Anthony Appiah suggests in his book, *The Ethics of Identity* (2005), identities bring with them moral and ethical obligations for the individual. Identifying with a particular label "carries ethical and moral weight" (Appiah, 2005, p.68). For example, identifying with a particular ethnic or religious group might carry obligations to follow certain dietary regulations, or identification with a specific nationality might entail duties of citizenship such as voting or serving in the military. Similarly, professional identities entail certain moral commitments. Again to quote Appiah, "One way that identity matters is when it determines what the codes of honor require of you" (Appiah, 2010, p. 62).

For physicians, accepting the identity of 'doctor' has traditionally been thought to carry a number of moral obligations. However, at the beginning of the twenty-first century, there are questions about what those obligations are. While many of the moral

constructs present in definitions of professionalism (honesty, integrity, compassion, caring) would be widely acknowledged as relevant, others are less clear. The changes in attitudes toward altruism have already been discussed. Some would also argue that physicians have public roles which carry with them an obligation to contribute to solving the health problems of the communities in which they live. Thus they are not only responsibility to individual patients (Gruen, Pearson & Brennan, 2004). In addition, there are times when aspects of physician identity appear to be in conflict with established standards of professionalism. For example, in a study carried out at Canadian medical schools, Kennedy, Regehr, Baker and Lingard (2009) concluded that nascent professional identity contributed to pressure upon trainees to act independently even in situations where they did not feel confident about their abilities. In this case, the moral imperative to provide the best care for patients would be in conflict with a (perceived) emphasis upon autonomy and decisiveness as elements of physician identity:

> Many participants felt that independence in thought and action was an identifying characteristic of doctors… Doctors were clearly understood to be an ambitious, autonomous group of people, and many participants attributed the pressure towards independence to this group identity. (p. 674)

Thus, identity operates within a social context, and can be viewed as being associated with particular moral requirements, as well as stereotypical traits or behaviors. Viewed through the lens of professional identity, medical professionalism is intimately linked to the individual's identification with the physician role. The questions that arise from this are: how is the physician identity constructed, and how do learners come to adopt this identity?

In considering the psychological development of the individual, the impact of early life experiences should not be underestimated. Attachment theory has provided insights into the importance of a stable environment in childhood for mental health in adulthood, and the cultural norms experienced by children have an impact on the values and beliefs held in later life (Bowlby, 1988). However, as the example above demonstrates, identity formation does not begin and end in childhood. The process continues throughout life as experiences and roles change. One way of understanding the process of identity formation is to consider the effects of early and later experiences. The processes by which social influences shape the individual have been termed primary and secondary socialization.

Primary socialization theory posits that behavior arises from social, psychological, and cultural characteristics that are learned through interactions with others (Oetting & Donnemeyer, 1998). Primary socialization involves the transmission of values and behaviors during childhood and adolescence through groups such as family and peer environments, or institutions to which children are exposed, most often schools. The effects of primary socialization are generally pro-social, that is, they support the development of empathy and concern for others. However, the personality of the individual can influence the strength of the social bonds, and may affect whether the individual adopts social norms. For example, children and youth who abuse drugs may be less susceptible to positive socializing influences because of a disrupted attachment to family and supportive peer groups (Oetting & Donnemeyer, 1998; Nurco & Lerner, 1999).

In their influential book, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*, Peter Berger and Thomas Luckmann (1966) contrasted primary socialization, which takes place during childhood within the family structure, and secondary socialization, which involves the internalization of institutions and their cultures. The "sub-worlds" of institutions are "more or less cohesive realities, characterized by normative and affective as well as cognitive components" (Berger & Luckmann, 1966, p. 158). For physicians, institutions through which secondary socialization takes place include medical schools, hospitals, and other components of the health care system. This process of professional identity among has been a subject of attention for several decades. It was described by Shapiro (1978) who wrote from the perspective of a physician with lived experience of the process of socialization, and it still figures in medical education research today. For example, a recent publication described a study using narrative analysis of essays and reflective writing by students during clerkship. The authors suggested that a common theme is that of liminality, existence on the threshold during the period of transition between the identities of 'student' and 'doctor' (Jones, Cohn, & Shapiro, 2012). Secondary socialization can be understood as the process that moves learners across the threshold into a new identity.

Elements Berger and Luckmann identify as characteristic of institutions include defined roles of various players, a specialized vocabulary, and a "legitimating apparatus" which may include rituals or symbols (Berger & Luckmann, 1966). All of these feature prominently in medicine, and the medical student who becomes socialized to the institution of medicine comes to situate him or herself within the social network of roles,

to speak the language of medicine, and to adopt the symbols of legitimacy (as in the White Coat Ceremonies held at many medical schools).

Secondary socialization builds upon primary socialization and therefore deals with a pre-existing self and internalized reality. Because of this, its effects are not experienced as being as ego-syntonic as the effects of primary socialization are, and thus, are more likely to be experienced as external or imposed. Berger and Luckmann (1966) argue that in some cases, initiation into a field may require a deeper immersion whereby the learner develops a sense of "identification and inevitability". In order for this to occur, there must be an enhanced degree of emotional engagement in the training process:

> The techniques applied in such cases are designed to intensify the affective charge of the socialization process. Typically, they involve the institutionalization of an elaborate initiation process, a novitiate, in the course of which the individual comes to commit himself fully to the reality that is being internalized. When the process requires an actual transformation of the individual`s ``home reality``, it comes to replicate as closely as possible the character of primary socialization… secondary socialization becomes affectively charged to the degree to which immersion in and commitment to the new reality are institutionally defined as necessary. The relationship of the individual to the socializing personnel becomes correspondingly charged with `significance.' (Berger & Luckmann, 1966, p. 164 – 165)

If, as Berger and Luckmann suggest, profound changes in identity require intense experience, then the rites of passage that have traditionally been part of medical training, including such emotionally-charged experiences as dissection or long hours of overnight call, may serve to heighten the emotional valence of medical training, leading to a higher degree of self- identification with the physician identity. As Hafferty (2009) asserts, "resocialization is most effective when the subject is repeatedly and purposefully stressed," and the arduous nature of medical training may have traditionally had the effective of promoting a strong physician identity: "a process – for better and/or worse – to change hearts and minds" (p. 64).

Nonetheless, for most physicians, the assumption of professional identity does not obliterate previous realities. Responding to Tavaglione & Hurst's assertion that beneficence has a greater moral claim upon physicians than honesty due to the nature of the physician's professional identity, Huddle (2012) points out that:

> …Medical practice, as physicians and patients experience it, is entwined with our other practices and with the norms that govern these—including the norms of our common morality such as truth-telling. When trainees join the medical profession, they do not experience it as a separation from the familiar norms that govern their nonmedical lives. Medicine is instead a context and an activity in which those familiar norms assume a new mode of governance, new emphases, and meaning specific to the demands of medical practice. Sometimes familiar norms undergo some contextual revision in medical practice. More often they retain most or all of their more general force when they bear in the medical sphere. (p. 15)

At the same time medical students are forming a professional identity, they are also involved in the more general process of forming self-identity. Anthony Giddens (1991) has written about the importance of the "reflexive project of the self" (p. 9) for people living in the modern era. He talks about the "primacy of lifestyle" (p. 81) wherein choices shape the identity of the individual. Lifestyle, the unique combination of choices the individual makes on many levels, gives "material form to a particular narrative of self-identity". Even trivial choices and routines are, "decisions not only about how to act but who to be" (p. 81). The dynamic relationship between the processes of personal and professional identity formation during medical training can be compared to the discussions about what it means to be a balanced physician.

In considering how identity is formed, Appiah presents two contrasting schools of thought. The first is the romantic vision of authenticity that says that one can discover, through reflection, a purpose in life which already exists and which involves being "true to who you already really are". The other is the existentialist version that suggests that you exist first and then "have to make a self up" (p 17). Appiah argues that both, taken separately, are false; there is a role for "creativity in making a self", but that is not to say there is "nothing out of which to do the construction" (p. 18). As well, we have collective dimensions of our individual identities that involve "socially transmitted conceptions of how a person of that identity behaves" (p. 21). The collective identity of any group with which the individual identifies him or herself can provide "scripts: narratives that people can use in shaping their projects and in telling their life stories" (p. 22). Our personal stories are constructed within narrative conventions, and our collective identities "structure possible narratives of the individual self" (p. 22). He talks about the

importance of “narrative unity, the ability to tell a story of one’s life that hangs together”, and the “project of self-making” that occurs in narrative form (p. 23).

Verkerk et al. (2004) put it this way:

> Given that responsibilities are defined by who we are, our connections to others, and what we care about, the negotiation of responsibilities involves three kinds of narratives: stories of identity, relationship, and value... Personal identities, understood as answers to the question, “Who am I?” can be thought of as fragments and tissues of stories that cluster around what we take to be our own or others' most important acts, experiences, characteristics, roles, relationships, and commitments. They are narrative understandings formed out of the interaction between one's self-concept and others' sense of who one is. (p. 36)

Given the influence of socialization and identity, it is not surprising that it has been widely recognized that the culture of medicine can subvert efforts to support and teach professionalism (Steinert, 2009). If the informal and hidden curricula controvert the formal curriculum about moral attributes (such as altruism, for example), it is inevitable that this will influence what the residents perceive to be the moral obligations of their professional identity. Rather than rely on the unexamined pressures of socialization to shape identity, some have attempted to provide a specific curriculum related to identity formation. For example, Clandinin and Cave (2008) describe an educational intervention where residents were encouraged to keep a “parallel chart” about their clinical experiences. A narrative inquiry approach was then used in a group setting

to encourage reflection with the goal of forming professional identity through stories and reflections on experience.

In summary, one way to think about teaching the moral aspects of professionalism is to view them as obligations associated with the professional identity of physicians. Seen this way, developing the resident's professional identity through secondary socialization, or through reflection upon socializing experiences (constructing narratives), offers the potential to influence moral attributes that might otherwise be viewed as inaccessible to educational interventions in PGME.

Honesty and Integrity in Medicine

At first glance, the question of whether honesty is valued in medicine seems to require little discussion or debate. In their sample of British physicians and trainees, Riley and Kumar (2012) found that honesty/integrity was one of the most frequently mentioned characteristics of professionalism, although their respondents also emphasized the importance of professional behaviors and relationships. The concept of trust is of core importance to professionalism (Morrison, Dowie, Cotton & Goldie, 2009) and trust is dependent upon honesty. As Huddle (2012) writes:

> In the course of medical training, truth-telling is seldom discussed, not because it is unimportant but because it is both critically important and uncontroversial among academic physicians and trainees, for whom the value of truth in academic work, in research, and in communication about and with patients is utterly taken for granted. (p. 16-17)

There is, nonetheless, an alternate view that honesty is not in the best interest of patients at all times. Verkerk et al. (2007) argue:

> There are, of course, situations in which for the patient's benefit it is in fact professional behaviour for a physician not to tell the truth, or to tell a white lie. Were doctors to give patients frank and very bad prognoses for which the patients were in no way prepared, we could indeed question their professionalism… Physicians are not infrequently confronted with situations where a choice must be made between telling the truth and leaving the patient a little hope. The decision depends on the specific situation and cannot be prescribed in advance. Physicians' professionalism consists of their consciousness of such conflicts and their awareness that they must be able to justify their decisions to others. (p. 664)

The belief that patients should not always be given information regarding their prognoses has been present for many years within medicine. However, in recent years there has been a change in how physicians practice, and most Western physicians now believe that respect for patient autonomy requires full disclosure. For example, in 1961, 90% of physicians were opposed to telling patients of a diagnosis of cancer, but by 1977 only 2 percent were opposed to doing so. Nonetheless, there is recognition that simply telling the truth is not sufficient, and that bad news must be handled in a sensitive manner, with adequate attention paid to communication skills and diverse cultural norms such as shared decision-making (Jotkowitz, Glick & Gezundheit, 2006).

It has also been suggested that there are situations in which it may be ethical for physicians to act deceptively if doing so will allow patients to gain access to services that

might otherwise be denied them by an unjust system, such as one which would restrict access to services based on financial considerations. This "gaming the system" may be seen as justifiable when done for altruistic purposes (Tavaglione & Hurst, 2012). However, others have argued against this view (Huddle, 2012; Sade, 2012).

In recent years, there has also been increasing attention paid to honest communication when medical errors have occurred. Everett et al. (2011) surveyed residents about truth-telling and lying in a variety of clinical scenarios. They found that over 90% of residents said that they would disclose the truth about medical errors, but 40% would not reveal a near miss event that did not impact on patient health. With regards to gaming the system as described above, 47.3% of these residents (practicing in the United States) stated that they would deceive a patient's insurance company in order for the patient to obtain additional benefits. Most of the reasons that residents gave for lying involved an altruistic rather than a self-serving motivation or justification (Everett et al., 2011).

Honesty, especially as related to truth-telling, may be easier to couch in behavioral terms than integrity. To date, much of the research on integrity as a psychological construct has emerged from the fields of business and organizational psychology where there are practical concerns regarding the role of integrity as it affects behavior in the workplace. Integrity has been found to be important for effective leadership and healthy work relationships, and an environment of trust. There has also been considerable interest in measuring integrity during the hiring process, as a lack of integrity has been associated with a variety of negative behaviors in the workplace. However, despite a substantial body of empirical research into integrity, including a

number of studies using standardized instruments, there are still conceptual limitations that pose challenges to researchers in the field (Barnard, Schurink & DeBeer, 2008; Wanek, 1999; Karren & Zacharias, 2007). Rather than using the term "professionalism", the business and human resources literature refers to "counterproductive work behaviors" (Fine et al., 2009). Insights from organizational psychology have yet to be fully integrated into the literature on medical professionalism.

Barnard et al. (2008) carried out a qualitative study of South African business leaders to develop a conceptual framework for integrity. The two most prominent themes they identified were "moral compass" and "inner drive". Having a moral framework and adhering to the principles of that framework was seen as foundational for integrity, and "behaviour with integrity is driven by one's willingness to act according to the internalised values, beliefs, norms and principles that constitute one's moral compass" (Barnard et al., p.43). The values, which were seen as being more universal than relativistic, included respect for others and a desire to lead a meaningful life. "Inner drive" was related to achievement and success. Authenticity was identified as important, as were moral reasoning and self-knowledge. Integrity was recognized to have a developmental component (which included parental role modelling and other early experiences) and to be strongly influenced by context. The authors acknowledged the complexity of integrity, including various conflicting theories as to what it comprises:

> From the research participants' constructions of integrity, various seemingly anomalous themes emerged that also reflect one of the core philosophical debates on the conceptualisation of integrity, which is integrity as moral responsibility versus integrity as authenticity (McFall, 1987)… In attempts to integrate these

> categories, it became evident that integrity can be conceptualised only when there is an understanding of the dynamic constructs underlying integrity that combine and interact in different ways in different situations. (p. 47)

The tension between integrity as moral responsibility versus integrity as authenticity raises the point that another way of thinking of integrity is as wholeness, which can be related to authenticity. For example, integrity of the person can be seen as related to the internal consistency of the self, as in this definition of character integrity by Horowitz (2002) that appeared in the psychoanalytic literature:

> Character integrity is the intrapsychic pattern of organizing, harmonizing, and using beliefs, motives, and values that concern self and others. These beliefs, motives, and values include intentions, expectations, goals, roles, and rules. These meanings are arranged in patterned but not necessarily compatible priorities. The intrapsychic meaning structure tends to both endure and slowly change, and effects how the person reacts to urges, pressures, and moral dilemmas. (p. 554)

It could be argued that integrity manifesting as observable and measurable behaviors may be related to the intrapsychic integrity of the self. The individual's beliefs, motives, values, intentions, and how they are prioritized, will influence how he or she interacts with other people within institutions and other social structures, including whether or not he or she is judged as displaying integrity.

Cruess and Cruess (2009) include honesty and integrity in a constellation of attributes (along with morality and ethical behavior) that are threatened by the increasing presence of market forces, commercialization, and conflicts of interest within medicine.

According to them, one of the fundamental expectations that society has of practitioners is that they will demonstrate honesty and integrity in their practice (Cruess & Cruess, 2009). As we shall see, this is an expectation that is shared by directors of residency programs in Canada.

Summary of Literature Review

There have been significant changes in medical education and practice over the past one hundred years since the professionalization of North American medicine began in earnest. The ideal of the physician as scientist has gradually changed so that medical education now aims to develop doctors who possess a wide variety of abilities, including communication, collaboration, and professionalism. The professional identity of physicians is undergoing rapid change, with younger physicians insisting upon shorter work hours and improved work-life balance (Twenge, 2009). Altruism, once the defining virtue of medicine, is increasingly seen as outdated or even counterproductive.

With these shifts in values and practices, there is an increased interest in professionalism as evinced by a large number of articles and studies. While there is a lack of agreement about what constitutes professional behavior, moral constructs appear in most definitions. In struggling to determine the best way to teach and evaluate professionalism in medicine, the question inevitably arises as to what role these moral constructs (particularly honest and integrity) play in professionalism, and whether they can be taught and evaluated. If fundamental moral attributes are related to an individual's identity, which is more influential, personal or professional identity? Are

qualities such as honesty and integrity amenable to being altered either by educational interventions or socialization processes in residency education?

Chapter III

Methods

Background to Current Study

This study builds upon and uses qualitative data from a mixed-methods study of how Canadian residency Program Directors interpret and integrate the Elements of the CanMEDS Professional Role into the PGME curricula. The group that conducted this research was formed in 2009 by the Dalhousie Division of Medical Education (DME) Program in Health and Medical Education Research (PHMER). The group was formed in order to study issues related to professionalism. The group was interdisciplinary, composed of both physicians (including two Program Directors) and non-physicians involved in education. As one of the goals of PHMER was to build capacity in medical education research within the medical school, the researchers had varying levels of experience. The group included members with PhD's in education and extensive experience in educational research, and others for whom this was their first experience in education research.

The study employed a sequential mixed methods approach (Creswell, 2009). Phase One (quantitative) consisted of a questionnaire survey, followed by Phase Two (qualitative) telephone interviews. The survey sample consisted of all residency Program Directors in the largest programs of the RCPSC; i.e., Internal Medicine, General Surgery, Psychiatry, Pediatrics, Obstetrics, Gynecology, Diagnostic Radiology and Anesthesiology. The questionnaire used in Phase One was sent electronically to 95 Program Directors (PDs), and a total of 46 questionnaires were completed and returned

(48% response rate). The final question of the online survey asked participants if they would agree to be contacted for a follow-up interview to explore topics from Phase One in more detail. Because the results obtained in the quantitative phase were used to develop the semi-structured interview used in Phase Two, the results will be briefly summarized, highlighting points that are especially relevant.

In the survey, the PDs were provided with a list of the 17 Elements of the Professional Role and asked to choose five Elements they thought were most integral to the Role. (Appendix II). The selections were not rank-ordered i.e. it was not possible to tell which of the five selected by each individual respondent was being given the highest priority. Of the 17 Elements, *Integrity and honesty* was selected as one of the top five by 44 of 46 respondents, occurring more than any other Element. The second most frequently chosen was *Morality and codes of behavior* (selected by 29 respondents) followed by *Compassion and caring* (selected by 24) and *Commitment to excellence in clinical practice and mastery of the discipline* (selected by 22). Other Elements were each chosen by less than half of the respondents. *Altruism*, which has been historically seen as a core defining aspect of medicine as a profession, was chosen by only 5 of 46 respondents as one of the five most important Elements in the Role.

When asked to report which Elements of the Professional Role were taught most often in their program, we found less variability. Respondents selected *Bioethical principles and theories* most frequently and tended to focus on the regulatory and statutory elements of the Professional Role. It should be noted, however, that these were also aspects of professionalism specifically mentioned in the accreditation standards used during Royal College accreditation visits in the period during which the study took place,

whereas other Elements of the Professional Role, while included in Royal College documents, were not present on the 'check-list' PDs and accreditors would have been using. The most commonly-reported method for teaching Elements of the Professional Role was role-modeling, with 94% of PD's reporting it took place in their programs. Formal teaching sessions on the Role were reported by 89%, largely concentrated in the earlier years of the programs. All PDs reported that teaching the Professional Role was done by clinical faculty from their own departments, but it was not uncommon to also involve outside experts. Evaluation of the Professional Role was conducted primarily by clinical faculty, and the most frequently used form of evaluation was direct faculty feedback in the clinical setting.

Using the results obtained in Phase One, the research group developed semi-structured questions for the qualitative interviews in Phase Two. (Appendix III) The main research questions addressed in the Phase Two qualitative stage were:

1. How does the CanMEDS Professional Role reflect Program Directors' 'personal understandings' of professionalism?

2. How do program directors define and teach "integrity and honesty"?

3. Do program directors believe that professionalism is innate, or something that can be taught?

4. What do program directors identify as the barriers to teaching professionalism, and how do they overcome them?

As mentioned above, in the Phase One quantitative portion of our study, *Integrity and honesty* was rated by 96% of program directors as one of the five most important Elements of the CanMEDS Professional Role, with no other Element generating that degree of consensus. Simply knowing that Program Directors valued these highly told us little about how they were interpreting these terms, or what it meant for the teaching of the Professional Role that they were ranked so highly. When selecting a focus for my thesis research, I chose to focus on how the Program Directors defined and taught 'integrity and honesty'.

I and one other research team member conducted the interviews by telephone in an office at the medical school. Telephone interviews lasted approximately 45 minutes, and were recorded as digital audio files that were transcribed by a professional transcriptionist. We asked participants for consent to use quotes, and informed them that they could withdraw their data from the study at any time. Between May 24, 2011 and July 5, 2011, I completed five interviews of Program Directors. The other interviewer, FB, also completed five interviews, bringing the total number of interviews to ten, of which nine were recorded and transcribed, and field notes recorded for the tenth. While additional interviews would have been desirable to ensure thematic saturation was reached, practical issues with contacting subjects willing to be interviewed required that the sample size be limited to ten respondents.

Steps were taken to protect the anonymity of the respondents by de-identifying the data as much as possible (removing names, references to location, and other details that might make the program identifiable) before the transcripts were distributed to the group members for analysis. It was not possible for the respondents to remain

anonymous to the interviewers, but neither interviewer has any connection to Royal College accreditation or other formal processes that might influence their responses, and we ensured we did not personally know the people we interviewed. I did not interview any Program Directors in my own specialty (psychiatry).

For my thesis, I analyzed the transcripts of nine interviews from the qualitative phase of the study, focussing especially on how the respondents spoke about honesty and integrity within the context of PGME. My research questions were:

1. What is the role of 'integrity and honesty' with respect to 'professionalism' as taught in Canadian residency training programs?
2. How can 'honesty' and 'integrity' be conceptualized and operationalized in the Postgraduate Medical Education context?
3. Do Program Directors believe honesty and integrity can be successfully taught to residents, or do they see them as immutable?

Theoretical Basis of Data Analysis

Qualitative approaches are used in research wherein there is an attempt to understand the meaning of phenomena for a particular group of people (Creswell, 2009). As such, a qualitative approach is appropriate for seeking to understand how Program Directors interpret honesty and integrity, particularly in the context of the practice of medicine and the accreditation standards of the Royal College. The analysis of the data drew upon interpretive and thematic techniques. The goal of interpretive analysis is to interpret and understand the findings, often described as themes, within the context of both the study and existing theoretical perspectives and evidence. This process takes

place in three phases: deconstruction of the data, interpretation, and reconstruction (Miles &Huberman, 1994; Sargeant, 2012). Braun and Clarke (2006) state that a theme "captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (p. 82). This process of interpretation resembled thematic analysis in that the essential task in thematic analysis is the identification of themes in the data set. Thematic analysis, commonly used in qualitative research, draws upon grounded theory (Strauss & Corbin, 1990; Kennedy & Lingard, 2006) and content analysis (Mayring, 2000), but it is a more flexible method of interpretation.

In the deconstruction phase of thematic interpretive analysis, which involved breaking data down into topics and categorizing it, I read through the transcripts of the interviews and developed a coding scheme drawn from the data and incorporating insights from my review of the literature. The 11 codes that emerged from the data were "Honesty and integrity", "Primary vs secondary socialization", "Role modelling/faculty development", "Ethics and morality", "Narrative", "Implicit and explicit nature", "Generational issues" "Role of the Royal College", "Overlapping Roles", "Remediation", and "Outside experts". Based on findings from the quantitative stage, I had already decided to focus on "Honesty and integrity." The sections coded as "Honesty and integrity" included attempts by the Program Directors to define these terms. However, there were significant associations with sections of the transcripts wherein respondents raised questions about the nature of these terms. In particular, respondents struggled with whether honesty and integrity were inherent or learned, and if learned, by what developmental stage? Is it possible to teach honesty and integrity in

residency training, and if so, how? I decided it was important to include these questions in the analysis.

As I reviewed the transcripts, I was also struck by how often respondents used examples, experiences, and stories to define and demonstrate what they meant by honesty and integrity. These "examples" and "stories" can be included in the category of "narratives". Narratives were not only evident in the manner in which responses given, but narrative shaped many of the formal educational interventions reported by the Program Directors. Thus, it seemed that understanding the role of narrative would not only provides insights into how program directors constructed their definitions of the terms, but also how they tried to teach honest and integrity to their residents. Thus, for my analysis, I focussed on the interpretation of honesty and integrity in medicine, the role these play in professionalism, and the teaching and learning of honesty and integrity. I also incorporated observations about the role of narrative.

One of the challenges in analyzing the transcripts was to separate out respondents' views regarding 'Honesty and integrity' from their thoughts about professionalism in general. This is not surprising given the central role accorded to honesty and integrity by Program Directors in the formulation of professionalism. It was particularly difficult to discriminate between the two when discussing how and when they might be taught and assessed. For example, one respondent (T2) spoke about the importance of role-modelling in teaching both professionalism and honesty. Another (T5) spoke about how assessing professionalism necessitated being able to "read the resident's mind", and then returned to the same point when asked about integrity. Thus, while I have attempted to

focus primarily on “Honesty and integrity” rather than “professionalism”, it has not been possible to differentiate completely between the two.

The second phase of interpretive thematic analysis is interpretation, where the themes are compared to each other and to other studies in the literature, and theories to explain relationships between them are developed. In this phase, I incorporated insights from my reading of the medical professionalism literature, the human resources business literature, and sociology texts. In particular, I was interested in Berger and Luckman’s insights about primary and secondary socialization and how this related to the formation of professional identity. Identity seemed to me to be related to both professionalism and integrity, and the question of how professional identity is constructed led me back to the topic of role modelling and faculty development, which had already emerged as themes from the data.

The other important connection was between professional identity formation and narrative. From my psychiatric training, I was familiar with the idea that personal life narratives shape identity. As described above, I was struck by how often program directors used examples of dishonesty and lack of integrity to define what they meant by the terms honesty and integrity. Thus, I chose to include sections on narrative in the data analysis, analyzing them both for the content and the structure of narrative. As Program Directors commonly used forms of narrative to teach professionalism, this seemed to support its inclusion.

In the final stage of reconstruction, the themes are arranged to demonstrate how they are connected. Reconstruction includes the incorporation of existing knowledge and

perspectives from the literature into the findings of the study at hand. In reconstructing the data, I will present the argument that honesty and integrity are seen by Program Directors as both facilitative and foundational in professionalism. They bear a complex relationship to the professional and personal identities of physicians. The developmental stage at which they are formed, and after which they are immutable, is controversial. Beliefs about honesty and integrity are often organized around narratives or examples, and methods for developing and teaching honesty and integrity (whether explicit or implicit) are highly experiential.

Thematic interpretive analysis can be used as a technique either to report on observed results and content, or to it may be used to identify processes related to the construction of meaning. As Braun and Clarke (2006) point out:

> Thematic analysis can be an essentialist or realist method, which reports experiences, meanings and the reality of participants, or it can be a constructionist method, which examines the ways in which events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society. (p. 81)

For the most part, I use thematic analysis to report the experiences and opinions of participants as gathered from their responses during the interviews. However, I will also devote some time to consideration of how the respondents use narratives in answering the questions posed to them. Several fairly lengthy quotes will be used to demonstrate the complexity of the narratives and the importance thereof.

Chapter IV

Results

In deciding which sections of the data to report, I have tried to focus on those segments where honesty and integrity were specifically discussed. At times, Program Directors responded to questions about these terms by talking about professionalism, or their answers led into a discussion of professionalism that was relevant to understanding their views about honesty and integrity. There was considerable overlap between respondents' understandings of the terms *honesty* and *integrity*, with some respondents using them interchangeably. So while it may appear I am conflating the respondents' views on *honesty, integrity,* and *professionalism,* I will attempt to keep them as separate as possible, and indicate when I am speaking about them collectively.

The Royal College has copyrighted many of the CanMEDS terms. They require that the Roles (including the Professional Role) and Elements be capitalized.

A few quotes may be used more than once. For example, a quote might be used to show how a Program Director responded to a question (such as by using narrative) as well as to discuss the content of the response itself; or a quote might refer to both honesty and integrity and thus be included in both sections of the results. Quotations selected are representative of the group of interviewees. Where a respondent held an opinion that was unique or markedly different from the majority, it is identified as such within the text accompanying the quote.

References provided for the quotations refer to the transcript of the interview from which it is taken. Some quotes have been edited for clarity and brevity. Where a

significant amount of text has been omitted, an ellipsis is inserted. In some excerpts, the interviewer's voice is included (I). The themes I will be examining are: the intuitive nature of the terms; interpretations of honesty; interpretations of integrity; questions about how teachable these are; and the effects of the learning environment.

Program Directors Define Integrity and Honesty

When asked about honesty and integrity, there was a high level of agreement among the respondents that these were key aspects of the Professional Role. None of the Program Directors interviewed suggested it should be excluded. However, respondents did not always have a ready definition for these terms, and often struggled to clarify how they were being interpreted in their residency programs. Some of the respondents seemed surprised at being asked to define the terms, or experienced it as being tested, for example, when one respondent commented: "…so integrity as a person means... Oh, no, you're testing me now, aren't you?" (T9). In general, the respondents appeared to find *Integrity and honesty* both intuitive and yet difficult to define:

> I: I was wondering if you could give me what your understanding of integrity and honesty would be, and why you think they might have been rated so highly.
>
> R: I can completely understand why they would be ranked so highly. I mean I think that there's a lot of I wouldn't say dishonesty but you know, a lot of lack of honesty... Again, it's one of those things that I think people have a gut feeling for but kind of defining or explaining why they are important, I'm not really sure… Integrity, it has to do more with your ethics and morals, I guess. Then it makes sense…

I: I think that's a common thing, that people aren't sure how to answer this. And as you say, they aren't really defined very clearly in CanMEDS.

R: No, they are not defined at all, right. They're just a list, right, but they're not defined in any fashion. But I think it's because they just assume that we all know what it means. (T1)

It is interesting to note that the respondent makes a distinction between "dishonesty" and "lack of honesty". While this is not explained further, it may be that he/she perceives dishonesty as a characteristic of the individual, whereas lack of honesty may be more situational or behavioral. Or perhaps 'dishonesty' is a more pejorative term. "Dishonesty" suggests the quality of honesty is flawed or corrupted, whereas "lack of honesty" implies a partial deficit that might be amenable to further development.

I: What is your understanding of these terms?

R: Integrity and honesty? Umm... [laughs]. It's such a simple question and yet I don't know how to answer it. I mean I think integrity is doing what's right because it's right, and not... And it goes into honesty in terms of if you didn't do something, you honestly didn't do it. (T2)

One of the respondents had previously participated in a consultation process where the group had discussed the meaning of the terms. During this process, he/she had been exposed to a definition that had resonated for him/her, and thus was able to define the term more readily than the other respondents. It appears that having previously reflected on the question of how to define the term may have made it easier for him/her to answer our question:

> That's very interesting because if I'm not mistaken, there was a consultative exercise about 3 years ago that I participated in… I remember from that day, one of the comments that was made, one that I agree with, is integrity is about doing the right thing when no one knows the difference. I kind of like that definition… You're doing the right thing when no one knows the difference. And in a sense, honesty is similar to that. (T3)

There was a common perception that honesty and integrity were foundational in medicine. Program Directors considered honesty and integrity necessary for other aspects of professionalism to operate, the "rate-limiting step", to use a scientific analogy:

> You can know the bioethical principles and theories but if you don't have integrity and honesty, you're not actually going to carry them off… All of them only work if you actually live them honestly. (T2)

> Program directors see first-hand the effect of residents who might be knowledgeable and competent in certain areas, but lacking in integrity and honesty. And really that is kind of like the bedrock of being able to work as a physician in our opinion. You know, in the end, if you're a physician and you're not honest and you don't have integrity… then all is lost. It's kind of a rate limiting step. (T10)

There was diversity of opinion regarding whether or not honesty and integrity should be viewed as "timeless" and unchanging. One program director felt that these were aspects of the Professional Role which would not be subject to shifting cultural values:

> There's some of these things that seem to relate to external expectations that might change as cultural values change, whereas there's other roles here that seem to be timeless. And I would think that integrity and honesty would be values that are timeless. (T3)

Conversely, another program director suggested that honesty might be perceived differently by the younger generation of physicians. Generational differences were a major theme in the interviews, with Program Directors tending to associate changes in duty hour requirements with differences in how the residents viewed professional responsibilities. Although honesty and integrity, as well as other moral or ethical aspects of the Role, were not generally discussed in generational terms, it is interesting to note that one program director speculated that they might be viewed differently by younger members of the profession.

> I'm getting old… The kids' definition of honesty may be a little different than my definition of honesty at times. (T1)

Although not speaking solely of honesty and integrity, one of the respondents raised the potential for changing attitudes towards the values associated with the Professional Role when he/she argued that the "post-modernist view of professionalism" had gone too far in emphasizing the contextual aspects of professionalism:

> I just want to make a statement again about the perception of context and what I would view as the post-modernist view of professionalism. Which is that it's not dichotomous, that we need to understand context, that there are systems at play here that we often overlook, and so on. And I do feel, as I said, that the pendulum

> has swung too far in education. And that accountability, discipline, stoicism, those kinds of things are not to be laughed at or under-rated… There were some bad things about the way people were trained many years ago but there were also some good things. And I think that the responsibility to patients, the grace under pressure, the doing right by the patient, the ability to delay gratification, those are things that I think have been to some extent eroded in our current climate. And I think that actually does relate to professionalism. And it's unfortunate that that has happened. (T10)

In summary, respondents frequently had difficulty providing definitions of honesty and integrity. Nonetheless, they saw them as being integral to the Professional Role, a foundation upon which other aspects of professionalism are laid. There was evidence of uncertainty with regard to whether the interpretation of honesty and integrity is likely to vary (either by different generations or by context), or whether they are timeless and unchanging.

Honesty: Truth-telling, Trust, and Communication

Most of the Program Directors interviewed found honesty easier to define and discuss than integrity. As we have seen, honesty can be thought of as an aspect of personality or behavior, or as the OED puts it, "uprightness of disposition" or "conduct" (OED, n.d.). Many of the comments made by the Program Directors suggest the latter interpretation. Honesty was often discussed in terms of observable actions rather than as a characteristic of the individual. 'Being honest' was framed as a pattern of behavior in which the physician's communication, particularly truth-telling, is key. Truth-telling was

seen as an important or even essential component of the professional roles and obligations of residents.

> Honesty I think is quite simply not lying – that would be a very obvious one. Not making up facts or stories... Or if they lie to the patient. So those are very blatant examples of poor honesty, I suppose… (T5)

> I: What is your understanding of these terms?

> R: That the individual is going to be straightforward and tell the truth and take responsibility for themselves. (T4)

In the last quote above, the respondent makes reference to the importance of taking responsibility. A similar point was made by a Program Director who spoke about the need for residents to "step up to the plate".

> We very quickly find out about the folks that are not 100% honest with us. And it's really disheartening, I have to say… You very quickly learn who is going to sort of step up to the plate. But maybe more importantly who is going to just always tell the truth, be upfront, whether it's about their patients, about the work they do in the program or about whatever. (T8)

Many of respondents talked about the importance of honesty, or honesty communication, in the relationships that residents have with patients and colleagues. Truth-telling was seen as important for effective collaboration within the health care setting. There were some comments in which respondents explicitly linked honesty with trust, and identified trust as an essential component of clinical practice. If the resident

cannot be trusted, then collaboration and team functioning is compromised. In particular, expressed the concern that if residents do not provide an honest account of how they have managed the clinical tasks delegated to them, other team members depending on them will not be able to adequately carry out their work. In the apprenticeship model of residency training, it is also important for faculty to be able to trust residents in order to supervise them appropriately.

> We have to trust our colleagues and our others in our profession. And if we say we're going to do something, we expect them to do it. And if they don't do it, they're not being honest. And therefore, they are not trustworthy. You know, we often work in teams, and to function as a team, you have to be able to trust your fellow team members. And if they are not honest, then you lose an important function of the team as a result. (T5)

> The student/teacher relationship is based on trust and we need to know that the person when they go to see a patient comes back and tells you what was. (T4)

One respondent mentioned disclosure of medical error, a topic which has garnered increased attention within medicine in recent years as a contributor to patient safety.

> To me a great example of honesty is disclosing a medical error that has had no measurable consequence. (T3)

One interesting theme that emerged from the transcripts was the association between honesty and effective communication skills. There was recognition that being honest involves more than transmitting truthful information from one person to another. Context, purpose, and delivery of honest communication were all identified as being

relevant to honest communication, and preserving or strengthening the relationship in which the communication takes place was seen as an important consideration.

> I think in general, honesty speaks not only to speaking the truth but also speaking the truth with an ethical guide. Speaking the truth in a way that will be in the best interest of the person… Not just saying it because you feel like you have to say everything… (T3)

> You understand the need to develop a skill set in terms of giving effective feedback to other people. I mean you can't be honest and brutal at the same time. You need to be able be honest with other people but do it in an effective manner that promotes learning. (T7)

One of the Program Directors (PD7) spoke at length about his/her belief that often residents hold back from telling the truth to patients or family members because they do not feel comfortable having the difficult conversations that may be necessary in medicine. This respondent, who appears to work in a pediatric medicine context, has developed a communications training program which uses simulation scenarios to teach residents the necessary skills.

> I developed the breaking bad news workshop that the residents all attend. It's an afternoon program involving simulation…. the residents are taught ways to communicate difficult information to families in an honest and, you know, speaking to them with integrity, and dealing with conflicts…. People tend to avoid things that they are not that comfortable with. So because of the weight of the information they are delivering, sometimes the residents don't want to tell the

> person the bad news. They actually avoid it and they're not really giving the parent an honest assessment of what's going on. And that's part of the goal of the workshop. So while it's difficult to tell somebody what's happened to their child, they can't just not do it because they're uncomfortable and hope that someone else is going to do it or whatever. They need to learn those skills. (T7)

Another aspect of honesty identified was the ability to be honest with oneself about the limits of one's knowledge and ability. This might require some capacity for reflection, or *Self-Awareness* and *Self-Assessment*, which are also Professional Role Elements.

> You're honest with families and colleagues about your limitations, you have insight in terms of your limitations, you acknowledge mistakes you've made and weaknesses that you have. In order to correct them, you have insight into that. (T7)

Most of the respondents, whether talking about honesty as a behavior or an attribute, tended to focus on the individual. Seen this way, dishonesty, whether due to a lack of skills, a clinical choice, or a personality flaw, originates within the resident himself/herself. One of the Program Directors (PD10) was clearly familiar with the professionalism literature that suggests that the institutions and traditions of medicine reinforce or create patterns of behavior which do not foster truth-telling. However, he/she was quite critical of that view. While acknowledging the influence systems and institutions have on the behavior of those who act within them, he/she expressed the

belief that these arguments have gone too far in downplaying the importance of individual responsibility.

> There's a lot of discussion about how it's the system and the system can make people dishonest, and the system puts unreasonable pressure, and how we train people. I feel again that we have gone too far. Yes, there are systematic problems and having a culture of shame and blaming people for making errors, etc., will obviously reinforce certain difficulties and problems. But there are many times situations where it's not intrinsic to the system, and blaming the system is just an excuse. And in fact, the responsibility has to reside in the individual. People are free agents and they have free will, and they have to take responsibility for certain actions. And there are residents that do lie and do cheat, and it has to do with their personality. (T10)

In summary, respondents related honesty to truthful communication, frequently linking it to the clinical context and often explaining its importance in terms of the trust and collaboration necessary to provide good patient care. While being honest with oneself was also mentioned, this appeared to be less central to how PDs understood the term. There was a recognition that telling the truth is not sufficient in itself, rather that honest communication needs to be thoughtful and contextualized.

Integrity and Personality

In general, Program Directors appeared to have more difficulty with describing what they understood by the term 'integrity' than 'honesty.' They did not describe integrity as a behavior, although they believed it strongly influenced behavior. When

speaking about integrity, Program Directors emphasized the importance of aligning actions with moral principles and standards. Acting with integrity was not a response to external rules or sanctions, but the outward manifestation of the individual's internal moral compass.

> It means maturity, knowing who you are and what you stand for. It means having your opinion that can be open to change in discussions with others. Meaning that you have a sense of self and a full awareness of who you are but with the openness to change your view in discussions with others, whereas maintaining your own sense of self, of value, of what you learned as you were growing up, what came into you from your family which was engrained in your upbringing, and what you consider to be most valuable and most important in your development as a person and as a physician… (T9)

One phrase that recurred several times when Program Directors spoke of integrity was "doing the right thing" as understood by the individual:

> I think integrity is doing what's right because it's right. (T2)

> I think integrity to me suggests that they are doing what they think is the right thing, even though it may not be the easiest thing to do. (T5)

While honesty (as truth-telling) might be situational, contextual, or caused by a lack of communication skills, integrity was seen as a fairly stable characteristic of the individual, closely related to personality. There was a suggestion that honesty might be a manifestation of integrity, or possibly secondary in some way to integrity.

> You know, I think integrity… honesty is probably a little bit easier. People can understand that concept. But I think integrity is a deeper thing that runs to the core of a personality (T7)
>
> I: Would you see integrity as being synonymous with honesty or would you see that as being a bit different?
>
> R: I think it's a different in the sense that I think of a people with integrity has principles, guiding moral principles through which they operationalize their behaviour and activities. And honesty would be one branch of that. (T7)

It appeared that for some of the respondents, the 'internal' nature of integrity was troubling from a pedagogical point of view. Some wondered if it were possible to adequately assess integrity in the learners because it requires a judgement regarding motivations as well as observable behaviours:

> Integrity, again it suggests that you can read their mind. And I try to bring it back to resident attitude. Which honesty and integrity are attitudes that relate, that result in certain behaviours. And I try to relate it to the behaviour... You can't really read their mind. (T5)
>
> They're learning how to be honest with families. They're learning the language that they need to feel comfortable to do that. Which is all terrific… but you know, are they incorporating or internalizing the importance of that? Don't know. I can give them the skills to do it. Whether they internalize the importance of that, that's a question of personal integrity and that's tough to evaluate. Because often

> people will do the things that you want to see but that doesn't mean they are doing them for the right reasons. (T7)

Can Honesty and Integrity be Taught in Residency?

One of the key uncertainties expressed by Program Directors in our study was whether or not the moral and value-driven aspects of the Professional Role, including honesty and integrity, could be taught in PGME. There was a wide recognition that these were highly influenced by early life experiences, and many of the respondents worried that if they had not been learned in childhood then they could not be taught later on. In the quantitative stage of our study, one respondent had written in a comment that certain aspects of the Role were best learned in `kindergarten.' We included a question about this in our semi-structured interview in Phase Two (Appendix III) but many of the Program Directors also raised the subject spontaneously. There was considerable skepticism about teaching honesty and integrity to residents, and concerns that deficits in early socialization could not be corrected in later training. Some respondents were quite adamant that if the value-driven aspects of the role were not present by the time residents entered a program, there was little hope that they could be inculcated in residency training.

> By the time they get here, they've developed those principles already. It's hard for us to really change them. (T1)

> A few of the more mature residents get it and they work on those things and they demonstrate those qualities early on, and I think those are the ones that probably

had it before they started their residency. They probably had it all their life and so it's easy to continue. (T5)

One respondent even wondered whether these characteristics might be innate, influenced by genetic 'hardwiring' rather than being learned at an early age.

I even would go further and say maybe there are some innate hardwired things… Like maybe you could argue that even in kindergarten, you could pick out those folks that are not going to have those qualities. Because I wonder if, you know, between nurture and nature, there's probably a component of both, but some of it is probably hardwired. (T8)

Given their concerns about being able to teach or remediate deficits in honest and integrity, it is not surprising that one of the ways Program Directors attempt to deal with the problem is by selecting residents who already possess these desirable qualities.

I: So what about integrity? Do you think integrity can be learned?

R: To be honest with you, I think largely not, unfortunately. I think they either have it or don't. And fortunately most, the vast majority have it. The minority that doesn't have it, I don't... We talk about this in our (residency selection) committee. We say, I can teach technical skills and knowledge. I cannot teach attitude. I can't train attitude. Or it's very difficult to change attitude. So I'd much rather take the resident who has the right attitude but doesn't have the knowledge or technical skills… If you're trying to change attitude, I think that's a very tall order. It's very hard to do. And so integrity would be one of the attitudes; if they don't have it, I think it's very hard to change. (T5)

That kind of quality or characteristic, that honesty, that integrity, that commitment to the patients and therefore probably to other things in your life, if It's not almost innately there to something extent, it's really hard to... I mean how do you teach that? And we sort of all say maybe you can't. Maybe we need to make sure we choose those folks. And then we can teach them all the other stuff. (T8)

However, there were other respondents who were more optimistic, and who did appear to believe that it was possible to influence residents to develop "values".

I: So how do you think we can help residents develop integrity?

R: Oh man, that's tough. They come with values, don't they? And they leave with values. And a lot of their values are shaped by their own choices in contexts that are really outside of my reach as program director and also their mentors. But there are times when a resident stumbles on a problem that we share, and I think reflection is a great way to do it… Yes, there will be some characteristics that are very basic to people's makeup, and our influence will be limited. But can we influence? Yes, we can. And should we? Yes, we should. (T3)

I would tend to be not that, sort of, hopeless. Yes, it is taught in the kindergarten but people change. And I think it can be taught. (T9)

One Program Director, a psychiatrist, spoke explicitly about the role of professional identity formation as a way of teaching about the Professional Role.

Right from the first day, orientation day, I invite a patient who has (disease) and has had bad experiences with psychiatry to talk to the incoming PGY1 and PGY2

> about what things they would look for in a good psychiatrist. We give each resident, as part of the orientation ceremony, a book that was written by somebody who had a mental illness, about the subjective experience of having a mental illness. So these are things to work with identity of being a psychiatrist, and trying to enhance capacity to take on a special role in working with patients that are very vulnerable. (T10)

However, this same Program Director also talked about the potential immutability of personality. While the respondent believes there might be value in using tests of personality in the selection process for residency he/she has come to realize that there is resistance to this suggestion, which he/she believes others may perceive as unethical:

> There is such a thing as a 5-factor model of personality. You can look at things like consciousness, those kinds of innate aspects of personality, and they've been shown to be innate. They're not state dependent, in fact. So my suggestion was that we should first of all do some research to look at which facets of personality predict future performance, and look at it across different disciplines – (Specialty #4), (Specialty #1), etc. And I've applied for that kind of grant but it wasn't supported. The feedback I received is a lot of concern that I'm doing something like eugenics almost. It seems like it's so radioactive that you would be allowed to focus on someone's personality... that you're doing something that's not fair or as if you're selecting based on height… In fact, there is research that suggests that it is predictive in business and in other areas. And they use it in the army, they use it in the police. I think that there is actually evidence that suggests that there is some science to this, and the only way that we could develop the science is by

> doing the research. But there's a lot of... It seems like there's a lot of reservations about the ethics of doing this kind of research. (T10)

In summary, many of the Program Directors believed that certain aspects of professionalism, including honesty and integrity, are established through early socialization, or may even by innate, an aspect of the personality. However, this view was not universal with others being of the opinion that it was possible to teach honesty and integrity in residency. It appears that for some respondents, concern that these qualities cannot be taught have led to more stringent screening of applicants for residency programs.

Effects of the Social Environment

While Program Directors struggled with the question of whether honesty and integrity can be taught at a later stage in development, they generally recognized the importance of the learning environment in forming residents' standards and patterns of professional behavior. They may have differed in how much they thought the later effects of professional socialization impacted on values that had been "learned in kindergarten", but there was acknowledgment that the behaviors of mentors and the unspoken rules in the clinical settings could be very influential in shaping professional identity and establishing norms of behavior.

Program Directors identified influences in the environment as occurring at two levels. The first was modelling of specific behaviors (whether professional or unprofessional) by individual faculty members. The second was the influence of the larger culture of medicine at their institutions, with values and rules to which residents

become socialized. When discussing how professionalism could be fostered at their institutions, faculty development was mentioned repeatedly as an important element for success, as it facilitated change both at the level of the individual teachers and the departmental culture.

"Role modelling" was the term commonly used by Program directors to describe the process by which residents learned particular behaviours through observation of other, more senior physicians. Many Program Directors saw this as the primary way that residents learned interpersonal behaviors related to patient care and collaboration. They also referred quite often to the "hidden curriculum" (Hafferty and Franks, 1994). As mentioned above, this term refers to what is taught through the real-life behaviors of physicians in the clinical setting, as opposed to the "formal curriculum" that is endorsed by institutional structures.

> We obviously try to ensure that our faculty display professionalism and role model it. Because we do talk a lot in our program about the fact that we can teach things all we want but if nobody models it then the hidden curriculum will of course win out and folks will sort of do what they see and not what we tell them to do. (T8)

> Another one is role modelling. It has almost become a bad word in the College recently, at least from an accreditation standpoint because they say, quote, "Role modelling is not enough." But still I think role modelling is a crucial way because residents are watching you carefully. And you know, we've always talked about the formal curriculum and the informal curriculum and all that, or from the

> hidden curriculum. And they pay attention to the hidden curriculum and it does shape their values and their behaviours. (T3)

Here we see respondents not only expressing the belief that role modelling is influential, but specifically associating role modelling with the concept of the hidden curriculum. The concept of the hidden curriculum appears to be a helpful one for the Program Directors, providing a language to describe how physician behaviors might support or sabotage the more explicit educational objectives of the training programs. The respondents gave some examples of behaviors that would be helpful for residents to see being modelled by faculty. Honesty was one of these:

> I don't think you can tell somebody to be honest and have integrity. I think you have to model that so that they see you in sometimes difficult situations relating to colleagues or to patients and families and taking the flack but you've been honest. I don't think a lecture on why you should be honest would be that helpful. (T2)

Although role models were generally spoken of in terms of positive examples that the residents might wish to emulate, one program director expressed the belief that exposure to poor role models could also be beneficial.

> I: And you said that you think that quite a bit happens through modelling as well.
>
> R: Well, I think so. And both good and bad. I've seen the residents in particularly awful situations. You can always learn from bad examples. (T2)

However, one of the respondents questioned how useful role modelling alone would be for remediating unprofessional behaviors:

> But when we do run into problems with people that, for whatever reason, didn't grasp that concept... They've seen a role model before and it obviously didn't affect them so I don't think we can change it. (T1)

In addition to expressing views regarding the importance of having good role models, Program Directors talked about how the culture of their Departments influences physician behaviors, and whether or not unprofessional behaviors are tolerated by the institution. It appears that in many centres there is an increased awareness of and discussion about issues of professionalism. However, there may be a disconnection between what is advocated by the institution and what actually takes place in the clinical setting.

> I would say that what I've noticed over the last few years is more of a discourse about these things and less of a tolerance as people come through the system for lack of professionalism… So I think we've come a long way… There's more of a discourse about it, is my sense. Whether that has changed how people teach or behave day-to-day, I don't know. I mean I hope so. (T8)

One of the respondents talked about efforts to move away from a 'culture of shame' in which medical errors are concealed because of fear of repercussions toward a more transparent system that allows for openness and honesty.

> I: Do you feel that throughout your department, people are committed to modelling the Professional Role?
>
> R: I think they have a long ways to go. Even for myself, I think we all can improve in that. And yet I think that it's improving. We've tried to use things like

> rounds to change the culture a little bit, to get away from this culture of shame where we're trying to hide our mistakes and get into more of an open dialogue where we're comfortable to look at ourselves and exercise in more of a reflective practice. (T3)

Before leaving the subject of how culture shapes professionalism, there was one group of residents identified by a few of the respondents for whom it was thought that secondary socialization to professional norms might be particularly helpful. This was the group of International Medical Graduates (IMGs) who had different cultural understandings of what constituted professional behaviors. A couple of respondents believed that IMGs might be a group of residents who would benefit more from teaching about professionalism than would Canadian graduates (although not necessarily with regard to value-driven aspects such as honesty and integrity).

> There are cultural differences when it comes to professionalism... For example, the person I just talked about who was speaking a certain way to the nurses, I think that when he started in the program, he thought that it was his role to be more directive. Whereas here in [city], the intent is that we might be more collaborative, and he simply didn't understand that. And yet I'm not so sure that it would be fair to say that he lacked professionalism. It may be that there was a difference in the cultural understanding of professionalism. (T3)

> We do have a number of residents who weren't raised in Canada, and sometimes they run into problems, not because they're not good people, just because their English, communication, their upbringing were different… But for the residents

> that were born and raised in Canada, I'm not sure that… it really changes their behaviours in any fashion. (T1)

As mentioned above, many respondents identified faculty development as important for teaching professionalism (as well as other non-traditional competencies). For many faculty members, basic information about competency-based education is a necessary starting point. Program directors themselves may be less comfortable with certain aspects of competency-based education, and they are frequently working with faculty members who did not train under CanMEDS and who find the language and emphasis unfamiliar, even if the concepts such as professionalism are not new.

> I think as a profession, we're most comfortable with the Medical Expert Role because that's something we all grew up with, we learned when we were trainees. And the non-medical expert roles, for better or for worse, we got by osmosis, if you will. We picked it up from people that we looked at and said 'That staff person is really professional. I like that. I want to be just like him when I grow up, or like her.'… If you look at all the program directors now, most of them I would say didn't grow up with CanMEDS, and it's not part of our training... And then the layer upon that, the non-medical expert CanMEDS roles, we weren't taught these on our own. And now we're expected to teach trainees. (T5)

> And I think part of the reason that we all have difficulty as a program feeling that they are evaluated is that while the younger people are coming up and developing their skills and knowledge in a CanMEDS framework, most of our staff do not. So they just take an ITER and they tick off Health Advocate, meets expectations

> all the way down. They really have no concept of how that translates into their practice. So, your evaluations that you get back can be not that meaningful as a result. And it's really because your staff, your faculty doesn't have an appreciation for the Role. (T7)

However, respondents also thought that faculty development initiatives were more effective when there was institutional or Departmental support, as well as adequate resources:

> Getting faculty participation at the level I think is different and really beyond the scope of what Program Directors can reasonably do in their jobs. So most universities like ours have faculty development opportunities for many of the CanMEDS roles but perhaps it depends on the individual department. Because there's no mandate that people have to take those. (T7)

> Our Chairman… started by choosing representatives from every division. And he tried to make sure there was a representation of not only division heads and folks that already had leadership positions but also up and coming and young faculty, and tried to get a very good mix from all divisions so that there was a lot of cross pollination. So they were all sent off to do this [name] Leadership course which was, from what I understand, quite intense… Not only was there leadership skills but also issues around professionalism and how we interact with colleagues, and also how we interact with trainees and model this for trainees. (T8)

One program director commented on the difficulty with many faculty development initiatives, namely those who attend are not necessarily those who would be most likely to benefit.

> The problem is the people that come to a faculty development session are usually the ones that are a) motivated and b) probably doing a reasonably good job already. The ones that you really want to come are probably not the ones that are going to come. (T8)

There were also comments suggesting that as the number of younger faculty who studied under the CanMEDS framework increases, so does the integration of the concepts associated with CanMEDS into the local educational culture.

> I found with the CanMEDS roles that there was initially, I think, a lot of eye rolling… But what I'm finding is that people are now getting where it fits and getting why we need to be explicit about teaching these things as opposed to just assuming we were all doing it, because we weren't, in my opinion. I notice it especially now that the younger faculty, the people who were growing up with it, are mid-career as opposed to earlier in their career. (T8)

> I don't feel pessimistic at all. I think what happens is with time, there's a tipping point. And you know, we train generations of residents and we teach these roles, and then they move into new jobs. And then eventually there's a critical mass of people who have a different way of thinking and they bring new values with them. And eventually the old values, they get squeezed out. So no, I've seen real changes just in 4 years, and feel very optimistic about the future. (T3)

In summary, Program Directors recognize the importance of honesty and integrity in clinical practice and PGME, but they struggle with how to define them. While honesty is often framed in behavioral terms as truth-telling, integrity is seen as more inherent to the character of the individual. As such, there is considerable skepticism regarding how possible it may be to teach honesty and integrity to residents. Nonetheless, the learning environment and the teachers that the residents encounter during training are acknowledged to be influential in forming professional identity and setting behavioral norms. Faculty development interventions and institutional support have been proposed as important factors for changing the learning environment, and thus, indirectly fostering professionalism and its associated qualities (such as honesty and integrity).

This provides an overview of the main findings from the interviews. However, there is another aspect of the transcripts which interesting to note. Quite often when they spoke about *honesty* and *integrity*, the interview subjects would use example, experiences, and stories to talk about these terms. Thus, if we look at how the respondents speak about these terms, and not just at what information they provide, we see that often they are using narratives to understand and convey their beliefs. As well, they describe a number of didactic teaching interventions that utilize narrative in one form or another. This narrative lens is applied to the results in the section that follows.

Narrative: Analysis and Teaching Strategies

When asked to discuss professionalism, and particularly honesty and integrity, respondents frequently used examples or descriptions offered in narrative form. It was

common for PD's to talk about these terms by translating them into particular examples of behavior by residents, or by relating personal experiences. As PD5 stated:

> I think, a lot of these terms are a little bit vague but I think they mean more when you apply it to specific scenarios. To me, that's... the best way to demonstrate what the meaning of these words are. (T5)

It appeared that Program Directors were drawing on their own experiences as they attempted to define the terms, especially narratives of unprofessional behavior.

> I've got one right now who is very dishonest. I've caught her lying numerous times. And they're really, really hard to remediate because usually they don't see it and also it's an inherent personality trait that you are really not going to probably change. And it's sort of you get frustrated because it's going to be then they're going to work with patients. We've unfortunately from time to time over the years had folks that were dishonest about things they had done or not done for their patients to their seniors and their staff because they thought they'd get in trouble. And then it ends up becoming a big deal. (T8)

> We have had one resident recently who I referred to be seen through our Physician and Family Support Program, and they recommended that this individual go to a one week assessment program. And I knew that the person needed it. It took some time to convince this person to go, and in the end, it was a very positive outcome. (T3)

> I have a senior resident right now who has managed in his longitudinal elective block to work only one day a week for two months, which I subsequently

> discovered when we looked in more detail into his work schedule. Now I will have no difficulties not having him...not crediting him for those two months and extending his residency program. I think that is what really should happen. (T9)

One of the program directors gave an example from his practice to illustrate the complexity of honesty and truth-telling in medicine:

> Do you actually have to say everything? You know, is truth telling always necessary? And in fact, there is a time when speaking the truth can be damaging. We have to be very careful about that too. I'll give you one example of that from my practice. There was a man who came to me as a [subspecialist]. He had no memory problems whatsoever but for whatever reason, he was very interested in knowing whether he had Alzheimer's disease. So we complied with the request to assess and found that he had no problem at all. He was normal. But he didn't accept that. He thought that there must be some problem. And he was sort of experiencing some of the minor changes in memory that happen to everyone as they age. Eventually he told me that the reason he wanted to know this is that not only did he want to die sort of before he developed the Alzheimer's disease but he wanted me to assist him and that that should happen before he actually develops Alzheimer's disease. So it puts me into a bit of a bind as to truth telling. Is it really in his best interest to tell him whether or not he has Alzheimer's disease? Now, you might say that that's his choice. But it's also my choice as to whether I assist him and whether I agree with it. So there are some of these tricky situations that come up with truth telling. But I think in general, honesty speaks not only to

> speaking the truth but also speaking the truth with an ethical guide. Speaking the truth in a way that will be in the best interest of the person. (T3)

Another Program Director talked about how useful it would be to have examples of particular behaviors and successful interventions used by others to address them.

> I think that the more challenge comes with the question – So what do I do if? …And maybe if we had some more sort of concrete examples of what do you do if the resident never comes to grand rounds or any other of the academic activities. What do I do then? And share within our programs what are other people doing… Because you know, we always respond with a certain degree of disbelief and surprise when something happens. And then you wonder if this is the only example in the world when this happens. Has it happened to anyone else? (T9)

To demonstrate how narrative or experience can shape and organize the understanding of professionalism, and honesty and integrity in particular, it is interesting to look at an extended example provided by one of the program directors using the framework of narrative (Clandinin & Connelly, 2000). The passage is included below, after which I will briefly discuss narrative elements of the text. The questions I posed and comments I made as an interviewer are included (underlined). In order to understand the development and flow of the story, the text is unedited (except for de-identifying the data).

> I: One of the comments that we had from one of the program directors was, "I'm not sure how effectively one can teach some of these qualities. Someone once

told me they either learn this in kindergarten or they don't." So it sounds like maybe you would agree with that, or?

R: Well, I think within reason. No, I'd say it was an experience we had with a resident. And this would be identifiable so obviously, you know, take it [inaudible].

I: Okay.

R: But on their application to our residency program, they actually... We had to go write a personal letter. And that's in so many ways the major part of what we look at. And (s)he in fact in medical school had lied. (S)he had forged the signature of a supervisor. And this was in his/her transcript. It was going to come out anyway. But what was very impressive is what (s)he learned from that. And we ended up accepting him/her. (S)he was an excellent resident. And I truly think... I mean I think honesty, you either have it or you're not. So to say (s)he was more honest than the other residents is hard to say. But I think (s)he in fact learned a valuable lesson from having done a really stupid thing. And I was glad that we gave him/her a chance.

I: That's an interesting story.

R: We had hours of debate because (s)he was an outstanding candidate in every other way. And had (s)he not addressed it in his/her personal letter, there is no way we would have spent 2 minutes discussing him/her. You know, because the facts were glaring. And it was one of these silly things where they attended all these sort of half day clinics at different people's offices and they had to get a

paper signed that they had been there. And the clinic, you know, was across the city or in a smaller town outside or whatever, and (s)he forgot to get it signed. And instead of going all the way back, (s)he forged the signature. But it was still the concept that (s)he forged the signature. As former director, I was the one saying, "I don't think so." You know, for someone to do something like that. You know, I've got to believe that you learned it in kindergarten or you didn't. But in fact, I was glad that I was made to see that maybe this was someone who learned from this. And I would say that (s)he did. And I don't... (S)he spent 5 years with us. (S)he did a fellowship. And we certainly never had any concerns.

I: So there was sort of a surprise there.

R: Yes.

I: And what do you think it was about that experience that helped him/her to learn?

R: I think what (s)he learned from that is you don't just have to be honest when you think it's important. You know, because to him her at the time (s)he didn't. I mean (s)he learned from this but at the time (s)he did it, it seemed like the proverbial white lie. You know, it just wasn't that important. Because it wasn't an evaluation, it was having the signature that you were there. You know? And I think what (s)he learned from that is you have to be honest in the little things too because it's a way of life.

I: Hmm. Yes, that's interesting, isn't it?

R: Yes. And like I said, I was the one who in the initial sessions was like there's no way I'm taking someone who lies. You know? But I think it was a case of people make mistakes. It was a really stupid mistake but (s)he'll learn from it. And (s)he learned from it.

I: Do you think that could have sort of been taught ahead of the fact? Do you know what I mean? Like if (s)he had had a lecture or something ahead of the fact. Or was that sort of something (s)he needed to learn from experience, do you think?

R: Well, I mean I think to have a lecture that says you shouldn't lie no matter whether you think it's important or not, I mean yes, maybe we could do that but it's hard to believe that it would have much of an impact. You have to learn.

I: Interesting. I'm thinking too that it sounds like something in his/her letter sort of showed reflection.

R: Oh, totally. I mean the whole thing was about reflection. (S)he led with it, you know. And I mean (s)he knew it was going to stand out in her transcript. But yes, I mean (s)he dealt with it right up front. (S)he explained it. (S)he didn't minimize it. (S)he didn't say it wasn't important. (S)he explained what happened and what (s)he did, and why (s)he learned that was stupid. I mean that was probably 6 or 7 years ago so I can't remember the exact details of what (s)he put in the letter but it was enough to convince the people who read the application initially to give him/her a chance, and actually enough to convince me.

I: Yes, that's an interesting story. Yes.

> R: But otherwise I agree with the comment that you either learn it in kindergarten or you don't. But I think maybe there are situations where people have to learn it again. (T2)

While there are several forms of narrative analysis, one approach that lends itself to this section, which presents a discrete narrative, is structural narrative analysis. This may include identifying the abstract, or key message of the story; the orientation, which includes characters and setting; the complicating action or plot, which may include a conflict or turning point; the evaluation, where the narrator comments on the meaning of the story; the resolution; and a coda which brings the story back to the present (Reissman, 2005).

One of the first points to consider is the way that there are two stories embedded within the passage above. The first is the narrative of the resident who forged a signature, was caught, learned a valuable lesson, and changed his/her behavior thereafter. The second is the narrative of the Program Director who believed that honesty was "learned in kindergarten", didn't want to accept the resident into her program, was persuaded to do so, learned a valuable lesson, and changed his/her views thereafter. The two stories are intermingled with each other, and the respondent goes back and forth between them, adding details, enriching the narrative. My comments reinforce the narrative frame. Twice I say, "That's an interesting story," once near the beginning and once at the end. The first time, it encourages the respondent to go on. The second time, it provides closure.

This is a very rich narrative. Using the framework of narrative analysis above, one can see that one key message is, as summarized in the final comments, "Honesty is something you learn in kindergarten – but sometimes you have to learn it again." There is also another message, however: sometimes we have firm beliefs (about things such as honesty being an immutable characteristic of the individual), and yet we may be proven wrong, and change our beliefs. In both of these intertwined stories, there are tensions and conflicts, and a surprisingly satisfying resolution. Both the resident and the Program Director are portrayed as being capable of learning. The time elapsing in both stories, and the personalities of those involved, are important elements. In this story, one can see how the respondent is framing his/her understanding of honesty not according to abstract terms and definitions, but through experience and the narrative constructed from it.

The preponderance of narratives in the transcripts is accompanied by descriptions of a number of teaching techniques that draw upon stories in one form or another. It should be clarified that in most cases, Program Directors only spoke generally about teaching professionalism rather than specifically about honesty and integrity. While lectures and other forms of didactic teaching were mentioned, program directors frequently talked about using narrative teaching strategies, although they were not explicitly identified as such. The narratives used included dramatized narratives, clinical narratives selected by the instructor, clinical narratives originating from the learners, and patient narratives. The way in which the narratives were constructed, presented, and explored comprised various degrees of interactivity with the 'text'. On one end of the spectrum, residents might watch a cinematic narrative (e.g. film), or read a patient narrative. A greater degree of interactivity was present when discussing a narrative with

others (e.g. clinical cases), and even more when residents would construct a narrative through role-play with colleagues or simulated patients. Finally, residents might be asked to write personal narratives based on clinical experiences, and reflect upon these narratives using a vehicle such as portfolio that would be then shared with a mentor or supervisor.

While the respondents did not generally provide a theoretical justification for the use of narrative, it appears that narrative was used to increase student engagement, to illustrate abstract ethical principles, to teach communication skills, and to encourage reflection. Some used fictional stories from movies or television:

> One of the ways we try to approach it that I think is the most entertaining, although it actually is quite a bit of work, is actually an idea I stole out of the United States, using movie clips, video, cinema sort of stuff. So we take... We edit clips from things like "House" and stuff that highlight some of the professionalism or not so professional actions that take place. And then we have discussions around those… And so trying to make it so that it's not so boring I guess is the thing. And that they can engage by using TV clips. And we let them pick. We have the residents actually go through some of the videos and pick things that they think are applicable or have entertainment value, if not educational value. (T1)

In this example, it is clear that resident engagement is a primary goal in using dramatic narrative. However, the respondent later expressed considerable skepticism about whether watching dramatized narratives was in fact helpful:

> I: So when you think about those things you told me about earlier that you were doing, like the watching movies and so on, are you optimistic that that has some effect on them?
>
> R: You know we're… I'd say yes and no… Like much of the stuff we're only doing because we have to, right. It's, in all honesty, a waste of 99% of residents' time and a lot of faculty commitment to do this stuff because if they got it as a kid, they got it now, right. (T1)

The respondent then goes on to suggest that there may be value in showing the video clips to residents who come from other cultures where the social norms are different, but there is little value for those who grew up in Canada. The sessions are largely for "entertainment" and satisfying the accreditation standards of the Royal College.

> But for the residents that were born and raised in Canada, I'm not sure that it... You know, for them it had some entertainment value but I'm not sure that it really changes their behaviours in any fashion. But we can check a box for accreditation purposes that said that we did this stuff. (T1)

Others used clinical examples:

> The clinical ethicist, he works in active practice as a clinical ethicist in one of our major teaching hospitals here… And so it's very easy for him to draw from his clinical practice and bring out CanMEDS issues. And it's actually very effective. (T3)

> We have the residents submit cases where they were involved and it had an ethical question or point to consider. And it's submitted to a group of 3 individuals. One is a [Specialist #5], [Subspecialty #3]. The second person is an ethicist, non-physician. And the third person is a lawyer who has a background in ethics in medicine. And so the 3 of them review the cases and then they actually run the session with the residents to first of all talk about some ethical principles and then they will bring up the cases to illustrate how they apply in that specific situation. (T5)

But there were questions about whether or not reviewing case scenarios affects behavior in a clinical setting:

> Because I mean almost everyone, even the most unprofessional person, if you gave them scenarios and asked them what, um, how a professional would deal with it or how it would be dealt with professionally, I bet you most people could answer it. It just doesn't, that doesn't necessarily translate into what they do. (T7)

Some of the clinical narratives that were used to teach the residents were explicitly cautionary tales. For example, one respondent described bringing in speakers from the Canadian Medical Protective Association (CMPA), the organization that provides malpractice insurance for Canadian physicians:

> You know, some of the CMPA people and stuff come in and just tell horror stories. And a lot of times, it doesn't really seem applicable. Some of the stuff is so farfetched that you wouldn't believe that people would really do it. I mean

> although obviously they do. But the residents have a hard time sort of grasping it in the context of things. (T1)

Some of the respondents described the use of role-play, in which the residents would enter into the narratives as participants. Role-plays could be with other residents or facilitators taking the roles, or an additional level of realism could be added through using simulated patients and other simulation techniques.

> So we might have a group of say 4 of the attendees there together, and it would be facilitated with volunteer physicians, clinicians who were there sitting at the table with them. And then one of the residents would take on the role of say the doctor who has made the mistake, and other resident would take on the role of, I don't know, a patient or a family member or whatever, and then the third and fourth one will play the role of observers. And then we would say, okay, you have 5 minutes. Now go ahead, it's your turn to disclose...Or we tell them what they need to do. You know, expose your error, or work it through… And so then they are actually practising it. You know, not just saying what they would do but doing it. And then there would be a dialogue after with the observers and also the facilitators would talk about how it went. And someone might then jump in and swap places and say, "Let's try this. Let's see how this would work." And then they would debrief on that. (T3)

> For example, I developed the breaking bad news workshop that the residents all attend. It's an afternoon program involving simulation and whatnot. So there's actors that are parents and your…. the residents are taught ways to communicate

> difficult information to families in an honest and, you know, speaking to them with integrity, and dealing with conflicts. So they have a lot of practice in a simulated environment in terms of that… So they get some feedback on how they do it and ways to language those conversations, to learn through those scenarios. (T7)

This last respondent (T7) gave a very detailed explanation of how he/she thought communication skills and honesty might be related, and why simulation might be helpful. This is quoted at length below so as to more clearly demonstrate how the intervention uses story to teach residents about honesty.

> I: So, you say that honesty comes up in these stations like with the simulation.
>
> R: Yeah, absolutely. Because it's breaking bad news, they're nasty. The scenarios are quite nasty. People tend to avoid things that they are not that comfortable with. So because of the weight of the information they are delivering, sometimes the residents don't want to tell the person the bad news. So they actually avoid it and they're not really giving the parent an honest assessment of what's going on. And that's part of the goal of the workshop. So while it's difficult to tell somebody what's happened to their child, they can't just not do it because they're uncomfortable and hope that someone else is going to do it or whatever. So they need to learn those skills.
>
> I: And when you say what has happened, I'm just wondering is there like a medical error component to it or is it...

R: Nope, there is no... One of them has a medical error component but that's minor. But the others are...

I: Just bad news.

R: You know, like there's a child, for example, who is a 2 month old infant that is ejected from a car that's T-boned. Dad's driving the car. The mom isn't there. The mom arrives in the scenario while the resident is talking to the dad about what's happened to the kid who is now gone for a CT and whatnot. And the mom arrives. And the residents are about 50/50 as to whether or not they give the parents all of the information about what they think is going on with the child. So they know because they've just been in this simulation with the baby and run a resuscitation with the infant. They know that this baby has suffered a severe brain injury. So some of them go in and tell them that and say that they are doing more investigation so that they can determine what has to happen now and the extent of the injury. Others defer and just say, you know, "We don't know anything now until we do the CT," which is actually incorrect. So they need to learn even though they are uncomfortable that they have to be honest with the family and give them the information.

I: Yeah, that is very interesting…

R: Yes. And part of it is just not knowing the language to use and feeling uncomfortable. Which is the whole point of doing the workshop. (T7)

In this example, it could be argued we not only see how residents learn communication skills, but also how they take on a certain role or identity as

professionals. It is not simply that they learn how to communicate honestly in this situation, but they begin to integrate the new professional identity which comes with a moral claim to being honest and forthright with patients and their families, even when this is difficult or unpleasant.

In the examples above, narratives were examined in a group setting. There was also one program director who talked about residents reflecting on their own narratives independently, and then sharing it with a preceptor:

> The residents are expected to meet with a faculty member to discuss their portfolio individually… they are supposed to discuss a situation or case where again the professionalism role was an issue. And they are supposed to be able to sort of describe the situation and then more importantly reflect upon their performance in the professionalism role, what they did well and how they could improve their performance in the future… What we look for is reflective pieces on their own experience unique to each resident. Right? So each resident follow different situations where an issue may come forward. And I think... And that's how physicians learn basically. I think they learn from their clinical experience. And I think that is a very powerful tool. I think that physicians need to be able to learn from experience. And I think it's more relevant to them if they can... If they reflect upon an article, it doesn't have the same emotional impact. If they reflect upon an actual experience where perhaps it caused a bit of emotional distress, I think that is a more powerful learning experience. (T5)

Despite the fact that there is an extensive literature on using patient narratives in teaching medical learners, the program directors mentioned this relatively infrequently.

> There's sessions that are specifically ethics…ethic related sessions that have families that come in and talk to the residents about their interaction with healthcare providers and how they'd like to be treated and that sort of thing, and their impact on their care. (T7)

> Right from the first day, orientation day, I invite a patient who has (disease) and has had bad experiences with (Specialty #4) to talk to the incoming PGY1 and PGY2 about what things they would look for in a good (Specialist #4). We give each resident as part of their kind of ceremony, kind of the orientation ceremony, we give them a book that was written by somebody who had a mental illness and about the subjective experience of having a mental illness. So these are things to kind of...to work with identity and with the whole kind of identity of being a (Specialist #4) and trying to enhance capacity to take on a special role in working with patients that are very vulnerable. (T10)

In summary, Program Directors draw heavily from personal experience when discussing honesty, integrity, and professionalism. Often they relate these experiences in the form of stories or narratives, many of which are quite lengthy and detailed. Similarly, when they attempt to teach professionalism and its component parts to residents, they tend to use experiential methods that likewise draw upon narratives, whether those of the resident or others. Narrative appears to be a medium through which Program Directors synthesize their understanding of what are otherwise abstract and complex terms.

Narrative means are commonly used in communicating and teaching about honesty, integrity, and professionalism.

As will be discussed below, the value of recognizing how commonly narrative appears in discussions of professionalism is that narrative can be seen as a key process in identity formation. Not only do the program directors operationalize honesty and integrity through narrative, narrative offers a potential means of understanding, and shaping, professional identity.

Chapter V

Discussion

Three main questions are addressed in this research project. First, what is the role of integrity and honesty with respect to professionalism as taught in Canadian residency training programs? Previous findings had identified that Program Directors considered honesty and integrity to be important in professionalism, but it remained unclear how they perceived the interrelationships between the three concepts. As will be discussed below, this project confirmed the importance of honesty and integrity, and also provided insight into how they fit within program directors' understanding of professionalism.

The next question was how 'honesty' and 'integrity' might be conceptualized and operationalized in the Postgraduate Medical Education context. *The Oxford Dictionary* defines the verb "to operationalize" as "to express or define (something) in terms of the operations used to determine or prove it", while to conceptualize is to "form a concept or idea of (something)" (OED, n.d.). Given that honesty and integrity were identified as important, knowing how these terms were being interpreted could provide more information regarding desirable goals or outcomes for professionalism education. However, the Program Directors did not easily provide nuanced definitions of honesty and integrity. When discussing honesty and integrity (and professionalism generally), respondents frequently provided examples and narratives that illustrated situations where physicians (both residents and faculty) either demonstrated these qualities or did not. Therefore, as discussed below, it appears that Program Directors find it easier to operationalize honesty and integrity than to conceptualize them. Nonetheless, they were

able provide some definitions and examples of behaviors which are both interesting and useful from a pedagogical standpoint.

Finally, I wanted to explore whether Program Directors believe honesty and integrity can be successfully taught to residents, or if they see them as immutable. The question of whether moral attributes of professionalism, such as honesty and integrity, can be taught effectively at the PGME level is a fundamental one for those interested in professionalism education. If we assume that they can be taught, a related question is how this can best be accomplished. While the Program Directors often expressed their uncertainty regarding how honesty and integrity might be taught and learned, one theme that emerged was the influence of experience, raising the possibility of designing interventions targeted either at the individual or the learning environment.

The Contributions of Honesty and Integrity to Professionalism

The statements made by respondents support the finding that Program Directors see honesty and integrity as important components of professionalism. This is in keeping with the work of others who have also found that honesty and integrity are viewed as central by various stakeholders in medical education and practice (Riley & Kumar, 2012; Green et al., 2009). Further, comments made suggest that honesty and integrity are not only viewed as important, but that they are seen to function as components of professionalism that allow the other aspects to 'work':

> You can know the bioethical principles and theories but if you don't have integrity and honesty, you're not actually going to carry them off… All of them only work if you actually live them honestly. (T2)

In explaining why honesty and integrity allow the principles and theories to "work", the respondents talked about them as being facilitative and/or foundational. These are closely related perspectives, although viewing them as "facilitative" is more congruent with a systems perspective on how the individual practices or acts professionally, whereas "foundational" emphasizes a structural view wherein certain behaviors or attributes of the individual are built upon others. Honesty and integrity may facilitate professional actions by the ways they operate within the clinical context, or they may represent fundamental characteristics of the individual upon which other attitudes and skills are established. The idea of "foundational" knowledge in medicine has a long history, but the term has generally been applied to basic sciences such as anatomy and physiology (Hazelton, 2011) rather than to aspects of professionalism. Program Directors used both models (facilitative and foundational) in a complementary manner. For example, one respondent (T10) referred to honesty and integrity as "the bedrock of being able to work as a physician" (foundational) and also as "rate limiting step" (facilitative). There was also speculation about how the two might be related to each other. For example, one respondent suggested that a person "with integrity has principles, guiding moral principles through which they operationalize their behaviour and activities. And honesty would be one branch of that." (T7) How honesty and integrity might facilitate behaviors and interactions characteristic of professionalism is discussed in greater detail below in the section on operationalizing honesty and integrity.

While it might be suggested that honesty and integrity were selected most often in the quantitative phase which provided the background for this research simply because they have a strong moral quality (and thus appear intrinsically more significant), it is

worthwhile noting that other moral Elements of the Professional Role had a lower rate of selection. This is particularly the case with altruism. In the quantitative phase of the study, *Integrity and honesty* was selected as one of the top five most important Elements of the Professional Role by 44 of 46 respondents, while *Altruism* was chosen by only 5 of 46 respondents. This apparent decline in the importance of altruism is in keeping with the findings of others (Kearney, 2005) as well as being congruent with arguments in the medical literature against the inclusion of altruism in educational outcomes (Bishop & Rees, 2007; Burks & Kobus, 2012).

From a historical point of view, the importance accorded to *Integrity and honesty* represents a significant shift from altruism as the defining factor of medical professionalism (Ludmerer, 1999; Hafferty & Castellani, 2010). This is occurring as a contemporary emphasis on physician wellness, and interest in 'work-life balance', are changing the workforce and the professional identity of physicians. Currently, the goal is to be a well-rounded individual, able to integrate both professional and personal life in a way that sacrifices neither (Johnson & Peacock, 2009; Peets & Ayas, 2012). With the decline of altruism as the defining value in the culture of medicine, self-sacrifice is no longer seen providing the motivation for ethical and moral practice. In contemplating why honesty and integrity may be replacing altruism at the heart of professionalism, one can consider several possibilities. One is that the decline in the importance of altruism has allowed honesty and integrity, which were always seen as important, to move into a newly-vacated first place. Or it may be that emphasis upon the character of the individual (as having integrity and being honest) represents an attempt to provide a new source of motivation for ethical practice, one that is independent of moral obligations

specific to the practice of medicine. Returning to the concepts of moral rules, moral ideals, and moral duties, "do not deceive", "keep your promises", and "do not cheat" are examples of moral rules, common to all humanity (Alexandra & Miller, 2009). These moral rules can be directly related to honesty and integrity, but they also resemble rules learned in kindergarten, as pointed out by many of the respondents. Do these rules hold any particular or special meaning for physicians? Is the application of these rules significantly different in professionalism than in life in general? These questions were never fully answered, although we shall see, part of the answer may be inferred from how they are operationalized.

In summary, honesty and integrity appear to be key aspects of professionalism as defined by program directors, not only providing a major contribution but also acting in a manner that is facilitative or foundational. This represents a shift from the historical view that altruism was the core value of medical professionalism. The fact that honesty and integrity are viewed as central may help to explain why Program Directors find professionalism a confusing topic, and why they question how successful teaching and learning professionalism can be. If professionalism consisted primarily of identifying ethical principles and recognizing the function of regulatory bodies (also Elements of the Royal College Professional Role) it would be much more straightforward to teach professionalism. On the other hand, if professionalism's key components are moral entities, then this poses challenges in defining, teaching, and evaluating professionalism, as discussed in more detail below.

Conceptualization of Honesty and Integrity

The interviews with Program Directors showed that they often had trouble articulating the meaning of honesty and integrity, both in an abstract sense and in operational terms within PGME. Nonetheless, most Program Directors in our sample appeared to have a strong intuitive sense of what these terms meant. For example, one respondent said, "it's one of those things that I think people have a gut feeling for but kind of defining or explaining why they are important, I'm not really sure…" (T1) Program Directors believe honesty and integrity are of key importance, and they have a general sense of what the terms mean, but when it comes to refining the definitions they often struggle. As discussed below, this is largely due to the tacit nature of knowledge about professionalism. However, it is also related to ambiguity about the nature of the terms themselves, an ambiguity that is especially problematic within the context of competency-based medical education (CBME). Not only do the words 'honesty' and 'integrity' appear in the list of Professional Role Elements, they also appear in the Enabling Competencies associated with the Professional Role. Below is the Enabling Competency that includes the terms, as well as the Key Competency to which it contributes:

> Key Competency: Physicians are able to: Demonstrate a commitment to their patients, profession, and society through ethical practice.
>
> Enabling Competency: Physicians are able to: Exhibit appropriate professional behaviors in practice, including honesty, integrity, commitment, compassion, respect and altruism.

(Frank, 2005)

Therefore, while there are no formal definitions of the terms *honesty* and *integrity* in the CanMEDS framework, they are embedded within the descriptions of the competencies. The hierarchical organization of CanMEDS is such that Enabling Competencies support Key Competencies, so that honesty and integrity are included in a list of 'appropriate professional behaviors' that contribute to 'ethical practice'. Yet are honesty and integrity, in fact, generally understood to be behaviors? Seen through the lens of CBME, it is important to remember that there should be a clear delineation of outcomes based on what physicians do in practice. The theory behind setting outcomes is they correspond to a particular action or set of actions the performance of which can be assessed, preferably by using standardized methods (Taber et al., 2010; Frank et al., 2010). In order for the Enabling Competency as written above to fit within the model of CBME, *honesty*, *integrity*, *commitment*, *compassion*, *respect* and *altruism* should not only influence behavior, but also actually *be* behaviors. If these are not behaviors, what are they? If they are not actually behaviors, then the behaviors associated with them need to be articulated in order to understand how they contribute to the Key Competency of 'ethical practice'.

This uncertainty regarding whether professionalism and its components are behaviors or something else has not been resolved in the literature. As Hafferty (2009) writes:

> This discourse is awash with often inconsistent and conflicting references to professionalism across a broad variety of social-cognitive entities such as

> behaviors, attitudes, values, motives, tendencies… While values, attitudes, and other dimensions of social life certainly coexist in a complex web of mutualities, they are not synonyms. (p. 54)

Similarly, Hodges et al. (2011) identified three discourses about professionalism in the medical literature: professionalism as an individual characteristic, trait, behaviour or cognitive process; professionalism as an interpersonal process or effect; and professionalism as a societal/institutional phenomenon, "a socially constructed way of acting or being, associated with power." (p. 360) He and his collaborators in the International Ottawa Conference Working Group on Professionalism found that there was "tension between those who wish to teach professionalism as essentially a moral endeavour and those who wish to have a list of attributes" (p.357).

Hafferty's answer to the question of what kind of thing is represented by terms such as *honesty*, *integrity*, and *professionalism* is to characterize professionalism as "values and self-identity" (Hafferty, 2009). As discussed above, values and self-identity are closely linked. Appiah (2005) wrote about the demands made by identity: when a particular identity is assumed, there are particular moral claims associated with that identity to which the individual must respond. Thus, the process of 'teaching' honesty and integrity involves the process of identity formation, which will be discussed in more detail below.

One of the primary ways Program Directors answered questions about the terms was through operationalizing them into observable behaviors. However, translating honesty and integrity directly into behaviors is not always possible. In particular, while

honesty may be conceptualized as truth-telling (a behavior), integrity is an attribute of the individual (albeit one that may lead to certain behaviors). Honesty can also be seen as a personal attribute. It is unlikely that Program Directors frame honesty in behavioural terms (truth-telling) in an attempt to make it 'fit' the CBME model, and they may not believe this a more accurate formulation than considering honesty to be an attribute of character. It may be that honesty as truth-telling was simply the definition that came most readily to mind as they attempted to make explicit what was otherwise tacit knowledge.

Cruess and Cruess (2009) define tacit knowledge as "that which one knows but cannot tell" (p. 79). When one of the PDs in the study described honesty and integrity as 'self-explanatory' (T7), he/she was responding to the tacit nature of knowledge about professionalism. Tacit knowledge is one type of personal knowledge, which incorporates procedural knowledge, experiential knowledge and episodic memories (Eraut, 2000). Learning takes place in response to specific events or situations (episodes), which then becomes abstracted to form generalized impressions. The process of combining episodic memories into semantic knowledge occurs on an unconscious level. Tacit knowledge is formed through experience and socialization, but it may not be immediately accessible when an individual is asked to speak of it explicitly, as was observed in this study. As Eraut (2000) writes:

> There are two aspects of this problem, awareness and representation. A person may be socialised into the norms of an organisation without being aware either of the learning or of what some of the norms are. Besides being an example of implicit learning, it is possible to imagine many types of event which might

> trigger awareness of these norms, for example transgressions by a third party might cause negative responses which then need to be explained. Sometimes, there is no problem in the 'telling' once awareness has been established: implicit learning may eventually lead to explicit knowledge. (p. 118)

Since tacit knowledge is based on experiences, it is not unexpected that instead of explaining what the concepts themselves meant, respondents often gave examples of actions or behaviors that might arise because a person possessed honesty or integrity (or not). In particular, they often spoke about times when 'transgressions' (professionalism lapses) occurred. The respondents had so much difficulty defining honesty and integrity independent of providing descriptions of associated behaviors that it is difficult to draw conclusions. However, one observation that can be made is that integrity was seen as "a deeper thing that runs to the core of a personality", intrinsic to the person and capable of influencing behavior through the mediating effects of values and the capacity to act consistently upon them. This is consistent with the finding by Barnard et al. (2008) that integrity was perceived as being related to having a moral framework and adhering to the principles of that framework: a "moral compass." There was also the observation that integrity was harder to evaluate for the very reason that it was related to the internal attitudes and/or motivations of the individual rather than being a behavior. (T5, T7) The operationalization of honesty and integrity by Program Directors will be discussed in more detail below.

In summary, there are two significant impediments Program Directors face when attempting to conceptualize honesty and integrity. The first is a lack of clarity as to whether honesty and integrity are behaviors, characteristics of the individual or moral

values. The second is the tacit nature of knowledge about honesty and integrity. Tacit knowledge is learned implicitly through experience and socialization, and is generally difficult to discuss in explicit terms, and as a result there were difficulties providing definitions (although there was a perception that integrity is in some way a manifestation of the values and character of the individual). As discussed below, operationalizing the terms appeared to be an easier task.

Operationalization of Honesty and Integrity

In attempting to define integrity and honesty, Program Directors often described them in terms of observable behavior, or they spoke of them as facilitative or foundational in carrying out the behaviors associated with professionalism. One of the advantages to operationalizing honesty and integrity into behaviors is that it permits examination of the interactions that occur between members of a social system rather than focussing on the characteristics of individuals (Hafferty & Castellani, 2010). The behaviors they associated with honesty and integrity included "taking responsibility" (T4), "acknowledging limitations" (T7), and "being honest with oneself" (T2). However, the most common usage of the term honesty was in reference to truth-telling. A number of examples were provided: disclosing error medical error (T3), reporting back to a supervisor (T4), providing feedback to others (T7), and communicating truthfully with colleagues, e.g. "being honest to radiology when you're trying to get an urgent MRI". (T2).

There was recognition that truth-telling is necessary for trust, and trust is essential in modern clinical medicine where care is usually delivered by collaborative teams. As

one respondent put it, “We often work in teams, and to function as a team, you have to be able to trust your fellow team members. And if they are not honest, then you lose an important function of the team as a result.” (T5) Trust is a key component of effective team functioning where it is sometimes referred to as ‘collective trust’ (Erdem & Ozen, 2003). Trust can be understood as reliant upon the responsibility and reliability of individuals (contractual trust), effective communication and disclosure (communication trust), and capabilities of team members (competence trust) (Reina, Reina & Rushton, 2007). In identifying honesty as important in trust and team functioning, respondents were acknowledging its importance in contractual and communication trust.

The Program Directors recognized ethical aspects of truth-telling, and the importance of sensitive and flexible approaches to telling the truth were emphasized. As one respondent put it, honesty should consist of “speaking the truth with an ethical guide… in a way that will be in the best interest of the person.” (T3) As another PD stated, “You need to be able be honest with other people but do it in an effective manner that promotes learning.” (T7) This same Program Director (T7) suggested that when truth-telling does not occur, it may be due to a lack of confidence and skills on the part of the resident, which are amenable to correction through educational interventions such as communication skills training. To that end, he/she has developed a breaking-bad-news workshop for residents.

Only one respondent (T10) directly discussed theories regarding the social contextualization of professionalism, acknowledging the importance of recognizing “the complexities of situations” and having “a contextual understanding of professionalism”. (T10) At the same time, he/she was quite critical of this approach, stating, “the

responsibility has to reside in the individual. People are free agents and they have free will, and they have to take responsibility for certain actions. And there are residents that do lie and do cheat, and it has to do with their personality." (T10)

Integrity, on the other hand, was not understood to be a behavior, but a powerful influence upon behavior. As such, it was only operationalized in the most general sense. Respondents spoke about how a person with integrity would align actions with deeply held beliefs. Three Program Directors (T2, T3, and T5) spoke about integrity as 'doing the right thing', regardless of consequences (T3, T5). However, as mentioned above, the fact that integrity is not an observable behavior means that it is very difficult to evaluate. As one respondent said, "Integrity, again it suggests that you can read their mind. And I try to bring it back to resident attitude. Honesty and integrity are attitudes that relate, that result in certain behaviours. And I try to relate it to the behaviour." (T5)

Honesty, then, was largely operationalized in terms of behaviors related to truth-telling and responsibility, both of which were recognized as important determinants of trustworthiness. Integrity was not associated with specific behaviors, but was seen as contributing to decisions to 'do the right thing' in accordance with deeply held beliefs or values. While these views would be generalizable to most social environments, the respondents frequently illustrated their answers with what could be termed examples, stories, or narratives drawn from medical settings. Narrative has been used extensively in medical education as a tool for teaching and learning (Charon, 2007; Calman, 2001). However, examples (or narratives, or stories) from their own experiences appeared not only to provide a useful means of answering questions about honesty and integrity, they also appeared to have been formative in their understanding of the terms (see the

extended example in the Results section). The use of portfolios for reflection upon events represents a narrative approach that encourages both the conceptualization and operationalization of professionalism. Narratives, and narrative techniques, also provided a means of operationalizing the terms for trainees through numerous educational interventions of a formal, didactic nature organized around narratives or cases.

In summary, it appears that honesty and integrity are most readily understood, or at least discussed, in behavioral terms. Assigning behavioral aspects to honesty and integrity makes them easier to evaluate, and operationalizing them in narrative form is a common approach to teaching. It also appears that experiences, and the narratives constructed from them, are important in the formation of the Program Directors' tacit knowledge about honesty, integrity, and professionalism.

Honesty and Integrity: Beyond Kindergarten

The final goal of this study was to explore whether Program Directors believe honesty and integrity can be successfully taught to residents, or if they see them as immutable. For the most part, respondents were sceptical about the likelihood of successful outcomes for efforts directed at teaching honesty and integrity at the PGME level. A commonly expressed opinion was that deficits in early socialization ('kindergarten' learning) would be difficult or impossible to correct. As one respondent put it, "it's the way your parents should have brought you up and not things that we are necessarily teaching residents. By the time they get here, they've developed those principles already. It's hard for us to really change them." (T1) Some PDs have adopted selection processes aimed at choosing applicants who already have desirable qualities

such as honesty and integrity rather than trying to inculcate these during residency. (T5, T8)

However, some respondents held a different view. (T3, T9) They believed that while it might be difficult to teach honesty and integrity in residency, it was not necessarily impossible. One pointed out that even if learning had occurred in kindergarten, there was potential for change (T9). Another pointed out that "a lot of their values are shaped by their own choices in contexts that are really outside of my reach as program director and also their mentors", but this did not mean there was no possibility of influencing them. (T3)

This introduces the question of when values are acquired, and whether residency is too late to inculcate them. Values are formed during the process of socialization (Oetting & Donnemeyer, 1998), and uncertainties about how to cultivate honesty and integrity in residents are also questions about the effects of secondary socialization in medical training. Both professional identity formation (which involves intrapersonal standards) and secondary socialization (which influences interpersonal behaviors) are dependent upon the context in which training occurs. Berger and Luckmann (1966) pointed out that socialization can have greater or lesser degrees of identity transformation, from milder forms of secondary socialization where the "institutional context is usually apprehended" (p. 161) to complete re-socialization. At the milder end, becoming socialized to adopt particular professional behaviors is a superficial form of professionalism that includes learning to speak with a particular vocabulary and dress in a certain fashion (Beagan, 2004). While it is relatively easy for residency programs to address the more superficial aspects of professionalism, the question of how powerful the

effects of secondary socialization are, and whether they have the capacity to fundamentally alter the attitudes and values formed in early life, remains unanswered, although some would suggest that an emotionally charged environment is necessary if profound change is to occur (Berger & Luckman, 1966; Hafftery, 2009).

To summarize, Program Directors were divided on whether or not honesty and integrity (and other moral aspects of professionalism) can be taught in PGME. There was a general perception, shared by both those who believed it could and those who thought it couldn't, that residents arrive with a set of values, beliefs and attitudes that are formed at an early age. Understanding how secondary socialization in the medical education environment influences professional identification and moral learning would provide useful insights into how best to teach professionalism.

Implications for Teaching and Learning

It is only recently that professionalism has been formally incorporated into the medical curriculum. As Cruess and Cruess (2009) observe:

> This is not because it was deemed unimportant… However, it was assumed that these values and beliefs, which are the foundation of the profession, would be acquired during the process of socialization of students… (p. 7)

However, there are now concerns that socialization alone is not sufficient for teaching professionalism and more explicit elements should be incorporated (Park et al., 2010). The finding from this study that honesty and integrity are central to PD`s definitions of professionalism suggests that explicit teaching may be difficult if those elements that are seen as most important are to be addressed. The challenge is that

understanding honesty and integrity draws heavily upon tacit knowledge, and tacit knowledge is not generally taught explicitly, but rather acquired by socialization (observation, increasing participation) as routine activities take on implicit meaning (Eraut, 2000). The more explicit the teaching about honest and integrity becomes, the more artificial it may seem. Alternatively, having working definitions of terms such as "integrity" may be satisfying for the individual and the institution, but it may also have the effect of shutting down further reflection about the nuances and implications of the term. It may be that challenging learners to wrestle with the ambiguity and uncertainty is more appropriate: however, this would be a challenge within the strongly positivist culture of medical education.

It seems that honesty and integrity should not be omitted from the curriculum simply because they are difficult to fit into the structure of competency based education. Teaching only those elements of professionalism most amenable to explicit instruction, such as knowledge of regulatory bodies, would likely lead PGME educators to feel as though the most important aspects are being overlooked. While it may be possible to operationalize aspects of professionalism such as honesty into behaviors, and link them to important aspects of professional life such as trust, team collaboration, and patient care, it seems likely that making this explicit (such as might take place in a lecture) would not have a strong influence on behavior. There is also evidence that judgements regarding moral issues are usually formed in response to affective responses, with the conscious cognitive processes of moral reasoning more likely to be used as a means of justifying decisions that have already been made rather than preceding them (Haidt, 2007).

However, socialization alone without proper attention to the learning environment runs the risk of passing on the worst aspects of physician behavior to learners. When talking about the learning environment, respondents in this study often referred to 'the hidden curriculum' and 'role modelling,' both of which incorporate tacit knowledge and operate through socialization. Role modelling has been demonstrated to have the potential for both positive and negative effects on medical learners, and the importance of having positive role models in the learning environment continues to be emphasized (Burks & Kobus, 2012).

Another way of looking at the inculcation of honesty and integrity is through the lens of professional identity formation. Professional identity formation has been identified by the Carnegie Foundation as one of the four main priorities for medical education (Cooke et al, 2010), and the potential exists for this to be a useful approach in studying tacit knowledge and the processes of socialization. One of the difficulties encountered with initiatives designed to 'teach professionalism' is that there is often a sense that what is taught is only superficially learned. It may be that the more profound behavioral and attitudinal changes that are the true pedagogical aims of these curricula would require that the learner adopt a professional identity that recognizes certain moral obligations (Appiah, 2005). There are some articles in the literature that have looked at socialization and professional identity formation. For example, Hamstra et al (2008) identify the connection between work hours, socialization, and professional identity formation. Kennedy et al. (2009) looked at how professional identity influences resident behavior. The association between professional roles and moral duties can provide a useful framework for facilitating understanding of both. However, there is still much

work to be done in determining how professional identity formation takes place, and how PGME can optimize the conditions in which it occurs.

In summary, the finding that honesty and integrity are perceived as foundational and facilitative in professionalism raises questions about how effective explicit teaching of professionalism will be if it focusses on these topics, yet how relevant it will be if it avoids them. The operationalization of honesty opens up possibilities for teaching, but at the same time, the effects of socialization will need to be understood and addressed. One way of doing this is by using a model that emphasizes professional identity formation. Linking professional identity and moral duties can help clarify the relationship between being a physician and accepting the obligations to be honest and have integrity.

Study Limitations

There are some important limitations to this study that should be acknowledged. The first is the assumption that the responses given by the Program Directors reflect their true beliefs or opinions. There are several reasons why this may not be the case. The Program Directors were not provided with the interview questions ahead of time, and had a limited time to consider their answers before responding. It was obvious that many of them had not given much explicit thought to how one might define the terms ‘honesty’ and ‘integrity’. While it may be that if they had been given more time, or were asked again at a later date, they may have been able to provide more sophisticated or nuanced definitions, part of the problem was the tacit nature of knowledge about professionalism. As Eraut (2000) writes:

> The problems faced by researchers investigating non-formal learning are very considerable. Not only is implicit learning difficult to detect without prolonged observation, but reactive learning and some deliberative learning are unlikely to be consciously recalled unless there was an unusually dramatic outcome. Worse still, potential respondents are unaccustomed to talking about learning and may find it difficult to respond to a request to do so. (p. 119)

Another factor that may have influenced their responses was the perceived desirability of certain answers, particularly in a situation where another physician conducting a study funded by the Royal College was interviewing them. Despite the assurance of anonymity, fear of sanctions may have led them to modify their responses to our questions.

Another limitation to this study is the fairly small sample size. While the purpose was to describe a phenomenon, and not necessarily to generate findings that could be used to make predictions about a larger sample, it is possible that we did not reach thematic saturation, and that interviewing more subjects would have led to further insights.

A final limitation involves our sampling procedures. In the qualitative phase, respondents were self-selected from the larger group, and as such may represent a subset whose responses are not typical of the larger group. For example, those who were interviewed may have a particular interest in professionalism education, and may be generally more optimistic about the possibility of teaching honesty and integrity to residents than would be typical of most Program Directors. For this reason, it is

particularly important not to try to generalize to how these qualities are perceived in Canadian programs in general. Nonetheless, these findings could provide the basis for designing other studies in future.

Future Directions

At the earliest stages of designing this study, many of the members of the research group (including myself) had hoped that our findings might eventually lead to greater consistency in how professionalism was taught and evaluated in Canadian residency training programs. After having conducted this research however, it appears to me that given the complexity of professionalism, and the abstract and contextual nature of the aspects perceived to be most important by those in the frontlines of PGME, it is unlikely that a standardized interpretation of the Role would be possible or even desirable. As Whitehead, Austin and Hodges (2011) state:

> There is a tendency to hope that outcomes-based frameworks will allow for clarity of standards, reproducible measurement of learners, and therefore an ability to state with certainty that all trainees will graduate with requisite knowledge, skills attitudes and behaviours… However, such quantification and certainty may not be possible…. Perhaps physician competencies can never be expressed as an objective ideal. Instead, as we seek to train the best possible physicians, we need to explicitly incorporate the context-bound and socially negotiated nature of professional competence into training models. While less satisfyingly simple, this will allow for a more sophisticated analysis of factors and processes essential to the training of highly effective health care professionals. (p. 692)

After reading and reflecting on the subject of professionalism, I have come to agree with Hafferty (2009) that "training in professionalism functions – and should function – at the level of socialization and at the level of values and identity" (p. 66). The process of identity formation is still very much a mystery: how does an individual enter into medical training as one person and emerge as another? There are many aspects of this question that I would like to explore further, including how the personal and professional selves are integrated, how individuals respond to the moral demands of new identities, and how narrative shapes identity for physicians. As a psychiatrist, it would be of particular interest to me to explore further the process of assuming the professional identity of 'psychiatrist' with all its complex history.

On a practical note, there are several presentations arising from this research. I recently participated as a co-facilitator at a workshop at the 2012 International Conference on Residency Education that incorporated findings from this study. By dissemination through presentations, workshops, and publications, it is hoped that Program Directors will become aware of approaches and practices which have been successful in other centers, and will adapt these to suit the needs of their own programs. Program Directors in our study expressed a sense of frustration regarding the ambiguity of the Role and a lack of confidence in teaching and assessing it. Knowing more about how other Program Directors conceptualize the Professional Role might provide some guidance, or it may be reassuring to Program Directors to learn that others share their concerns. Nonetheless, it will be important not to present our findings in a superficial 'cookbook' fashion. Professionalism, and in particular its moral aspects such as honesty and integrity, cannot be taught in a manner divorced from context.

It is hard not to feel as though medicine is going through a great transition. This might be hard to defend: every societal institution is always in transition, including medicine, and there is no standard by which to accurately judge the significance or importance of change. And yet, the surging interest in professionalism in medicine seems to reflect a basic uncertainty, and perhaps insecurity, about the present and future of doctoring and doctors. Physician educators express this uncertainty when they ask, how am I supposed to teach professionalism? And there are other questions: Why don't the young doctors act and think like the old ones? What do we physicians value now? Should we be nostalgic for the past, or reject it as elitist and hypocritical? Was altruism an ideal worth sacrificing one private life and family for, and if not, what is supposed to constitute the moral core of medicine as we move forward in an age that is sceptical of ideals?

Each month, more references are added to the Pub Med databases as the medical education journals overflow with more professionalism articles to be read, arguments to be considered and teaching approaches to be tried. Meanwhile, clinicians throw up their hands and protest that these things cannot be taught, even as they struggle to define what 'these things' are. It is strange, disconcerting, and perhaps even sad that all of these articles have not done more to reduce the uncertainty and anxiety of many program directors. The literature is replete with approaches to understanding and teaching professionalism that are innovative, interesting, creative, challenging. However, what the literature offers is an ever-growing diversity of views, not a single answer, and complexity rather than simplicity.

This ambiguity is bound to be unsatisfactory for many program directors and other physician educators. At least, it is right now. However, it seems to me that there is reason to be optimistic that the concerns expressed by the educators of today may be addressed in the future. If there really is a dramatic cultural shift in the values and responsibilities of the medical profession, then the younger generation of physicians will be better equipped to handle the issues because they will have a lived understanding of them. Solutions for what constitutes professional use of social media by physicians will come from younger generations rather than older ones. The younger generation of physicians has already proved itself capable of making dramatic changes to the hours of work required during residency. If, as seems likely, much of the interest in professionalism is arising from the increased emphasis on work-life balance by the younger generation of physicians, this will gradually become less of an issue as the ranks of clinicians fill up with those trained under new reduced hours. Already, the assaults on altruism as a defining ideal of medicine have begun. While the implications for the health care system are still unclear, the days when doctors routinely worked very long hours and sacrificed their personal time for their patients' care are gone, unlikely to ever return. Whether this is a good or bad thing depends on one's point of view, but questions of value do not change what is happening. The definition of professionalism is being rewritten regardless of whether we know what it should say or not.

Chapter VI

Conclusions

My thesis research began with the observation that the Professional Role as it is currently understood by Canadian residency Program Directors is strongly associated with honesty and integrity, and my research sought to explore the role of integrity and honesty with respect to professionalism as taught in Canadian residency training programs. Results have confirmed the central role of honesty and integrity and have also shown that honesty and integrity are perceived as being facilitative or foundational for medical professionalism.

In exploring how can honesty and integrity can be conceptualized and operationalized in the Postgraduate Medical Education context, it became clear that Program Directors found it easier to operationalize the terms than to conceptualize them. Despite the Royal College's requirements that professionalism be explicitly taught and evaluated, the Program Directors commonly have an implicit or tacit understanding that stands in conflict with this requirement. When asked to elaborate on what is meant by these terms, they often respond with examples of behaviors, whether desirable or undesirable. Nonetheless, they were able to describe honesty as truth-telling, while they associate integrity more with the personality or identity of the resident.

Another question was whether Program Directors believe honesty and integrity can be successfully taught to residents, or if they see them as immutable. There is a sense among many Program Directors that what they are being asked to do may exceed their level of influence. They recognize that both primary socialization ('kindergarten'

learning) and secondary socialization play a part in forming professional identity, and they may be willing to put some effort into training in reflection or communication skills, but the moral aspects of identity seem to them to be too profound to alter during residency training. For some, difficulties in remediating dishonest residents have led to a high degree of pessimism regarding the teaching of professionalism.

However, others remain more optimistic. While some residents may experience difficulties, for the majority of residents, a foundation of honesty and integrity is already present, and explicit teaching may be useful to consolidate tacit knowledge. The use of reflection, narrative teaching methods, identity formation and attention to the learning environment all hold promise as means of positively influencing professional identity. Honesty and integrity are examples of what Mark Kingwell (1998) calls 'essentially contestable concepts' (p.6). They are also inarguably important qualities for doctors to have. To quote a Program Director: can we influence? Yes, we can. And should we? Yes, we should.

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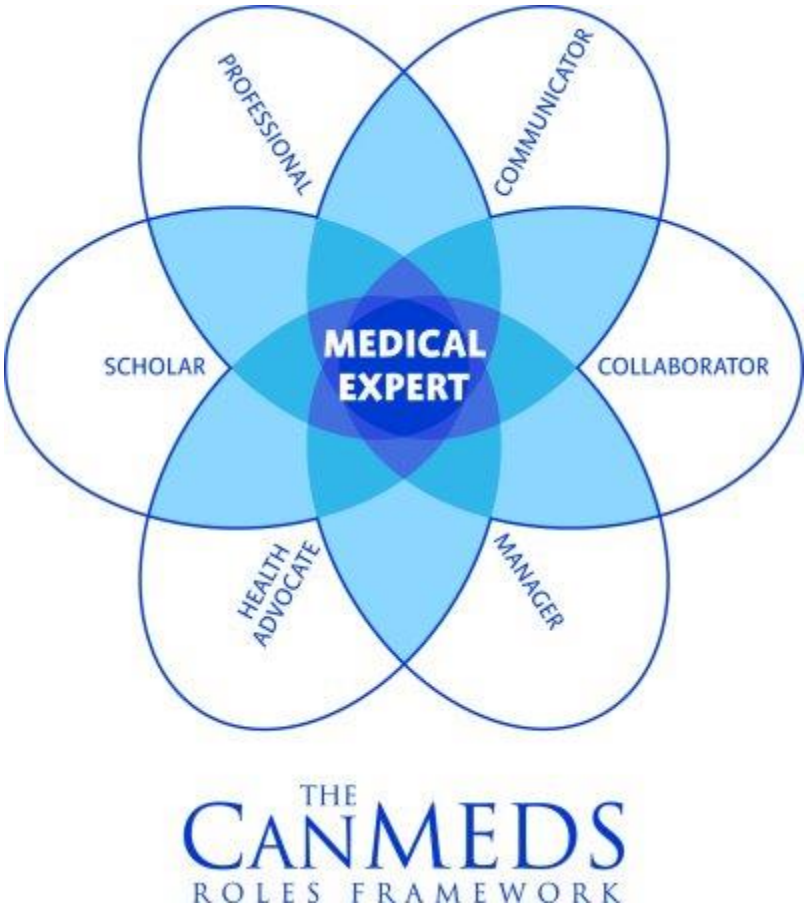
Appendix I

The CanMEDS Competency Framework Diagram



http://www.collaborativecurriculum.ca/en/modules/CanMEDS/CanMEDS-intro-background-01.jsp. Accessed November 12, 2012.

Appendix II

CanMEDS Professional Role

Definition: As *Professionals,* physicians are committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behaviour.

Description: Physicians have a unique societal role as professionals who are dedicated to the health and caring of others. Their work requires the mastery of a complex body of knowledge and skills, as well as the art of medicine. As such, the Professional Role is guided by codes of ethics and a commitment to clinical competence, the embracing of appropriate attitudes and behaviors, integrity, altruism, personal well-being, and to the promotion of the public good within their domain. These commitments form the basis of a social contract between a physician and society. Society, in return, grants physicians the privilege of profession-led regulation with the understanding that they are accountable to those served.

Elements:
• Altruism
• Integrity and honesty
• Compassion and caring
• Morality and codes of behaviour
• Responsibility to society
• Responsibility to the profession, including obligations of peer review
• Responsibility to self, including personal care in order to serve others
• Commitment to excellence in clinical practice and mastery of the discipline
• Commitment to the promotion of the public good in health care
• Accountability to professional regulatory authorities
• Commitment to professional standards
• Bioethical principles and theories
• Medico-legal frameworks governing practice
• Self-awareness
• Sustainable practice and physician health
• Self-assessment
• Disclosure of error or adverse events

Key Competencies: *Physicians are able to…*

1. Demonstrate a commitment to their patients, profession, and society through ethical practice;
2. Demonstrate a commitment to their patients, profession, and society through participation in profession-led regulation;
3. Demonstrate a commitment to physician health and sustainable practice.

Enabling Competencies: *Physicians are able to...*

1. Demonstrate a commitment to their patients, profession, and society through ethical practice
1.1. Exhibit appropriate professional behaviors in practice, including honesty, integrity, commitment, compassion, respect and altruism
1.2. Demonstrate a commitment to delivering the highest quality care and maintenance of competence
1.3. Recognize and appropriately respond to ethical issues encountered in practice
1.4. Appropriately manage conflicts of interest
1.5. Recognize the principles and limits of patient confidentiality as defined by professional practice standards and the law
1.6. Maintain appropriate relations with patients.

2. Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation
2.1. Appreciate the professional, legal and ethical codes of practice
2.2. Fulfill the regulatory and legal obligations required of current practice
2.3. Demonstrate accountability to professional regulatory bodies
2.4. Recognize and respond to others' unprofessional behaviours in practice
2.5. Participate in peer review

3. Demonstrate a commitment to physician health and sustainable practice
3.1. Balance personal and professional priorities to ensure personal health and a sustainable practice
3.2. Strive to heighten personal and professional awareness and insight
3.3. Recognize other professionals in need and respond appropriately

http://www.royalcollege.ca/portal/page/portal/rc/common/documents/canmeds/resources/publications/framework_full_e.pdf. Accessed November 12, 2012.

Appendix III

Semi-Structured Interview Guide

Once the program director is on the line:

- *Thank them again for agreeing to participate in this study.*
- *Remind them that the interviews normally take about 30-45 minutes; ask if they are in a quiet space where they will not be disturbed. (Reschedule if necessary – you can do this on the spot yourself, or have Katie follow up with the PD or their admin person.)*
- *Remind them that this interview is being audio recorded and professionally transcribed, but that any potentially identifying information will be removed from the transcript.*
- *They are free to withdraw from the study any time prior to the publication of results.*
- *Any questions about this? Let's begin…*

1) Can you please introduce yourself, your program, and how long you've been program director?

2) Tell me about how the CanMEDS Professional Role is taught and evaluated in your program.

3) What kinds of things do you think of when you think about professionalism? Does the CanMEDS Professional Role reflect your personal understanding of professionalism? Is professionalism reflected by the 17 'elements' of the CanMEDS Professional Role? Is anything missing?

4) Do you find that the CanMEDS Professional Role overlaps with any other CanMEDS Roles? If so, how?

5) In our survey, "integrity and honesty" was rated by 96% of program directors as one of the most important elements of the CanMEDS Professional Role. What is your understanding of these terms? Why do you think they were rated so highly? How can we help residents develop integrity?

6) Can you discuss the following comment made by a program director regarding the CanMEDS Professional Role: *"I am not sure how effectively one can teach some of these qualities. Someone once told me they either learn this in kindergarten, or they don't!"* What are your reactions to this comment? Do you agree/disagree? Why or why not?

7) Our survey data suggests that over time, program directors become more comfortable with teaching, but not evaluating the CanMEDS Professional Role. Can you comment on this? Why do you think that this could be? Can you think of any factors that *help* or *hinder* the teaching and evaluation of the CanMEDS Professional Role at your site? If there are barriers, what strategies do you use to overcome them?

8) Is there anything else about the CanMEDS Professional Role that you feel is important and you would like to comment on? Anything about teaching the Role? Evaluating the Role?