

Facilitating professional attitudes and professional development

Author

Dr Jonathan Martin MMedSci (Clin Ed), MRCP
Senior Education Fellow
Department of Primary Care & Population Sciences
University College London

This paper was first written in 2003 as part of a project led by the London Deanery to provide a web-based learning resource to support the educational development for clinical teachers. It was revised by Judy McKimm in 2007 with the introduction of the Deanery's new web-based learning package for clinical teachers. Each of the papers provides a summary and background reading on a core topic in clinical education.

"Why are so many doctors unhappy, despite their interesting work for which they are well rewarded; and why are their patients unhappy about the care they receive?" (Falder, 1998)

"The public's unfulfilled expectations of doctors are crucially about attitudes" (Irvine, 1993)

Aims

This paper focuses on professional development with an emphasis on facilitating appropriate professional attitudes – an area of medicine and medical education sometimes ignored.

This paper:

- provides you with skills and knowledge to assist and support trainees/students with their professional development
- enables you to facilitate and record your own professional development

A series of exercises ask you to take a reflective approach to the material contained within this paper, particularly that which presents most personal challenge to you.

Contents

- Some definitions - 'attitude' and 'professional development'
- The need to assess the attitudes of your students and juniors
- Defining a basis or gold standard against which such assessment can be made
- The relationship between attitude and behaviour
- How to challenge inappropriate attitudes and behaviours, and justify your reasons for doing so
- Using the 'lifelong learning cycle' to help plan a trainee's professional development

- Role modelling and mentoring
- Information regarding aspects of a trainee's professional development
- References

FACILITATING PROFESSIONAL ATTITUDES

Section 1 Introduction to facilitating professional attitudes

Before looking at a working definition of 'attitude' in Section 2 it would be wise to consider why this area is, or should be, of importance to medical educators, and the medical profession in general.

Activity 1

Reflect on the following statements and (a) note the *reasons* why you agree or disagree with each, and (b) consider in what ways each is important in terms of the attitudes of those within the profession towards their patients and colleagues (the questions contained in parentheses may help you in this process):

- ⇒ Societal expectations of doctors have changed over the last few decades.
- ⇒ Medicine in general, and doctors in particular, are usually portrayed in negative ways in the news (what recent UK examples spring to mind?).
- ⇒ The interaction between a doctor and a patient is moral in nature.
- ⇒ The attitude of a doctor towards a patient has an effect on that patient's health.
- ⇒ Patients usually litigate against doctors because of a perception that the doctor did not *care* about them (all doctors make mistakes, whether actually negligent or not, so why are some doctors more likely to be litigated against than others?).
- ⇒ Medical education has a dehumanising effect on medical students.

What conclusion do you reach about the importance of professional attitudes?

For my personal views on the above read:

Martin J, Dacre J. Professional attitudes: why we should care. *Clin Med* 2002;2:182-4.

Section 2 Definition

Over the course of this paper we will look again at some of the issues raised by the statements in Section 1, but before doing so it is important to define what is meant by the term 'attitude'.

Read through the following carefully. Key concepts are in bold.

What is an attitude?

There are many definitions of attitude in the psychological literature. Perhaps one of the most useful is to be found in the book *The Psychology of Attitudes* by Eagly and Chaiken (1993) from which much of the following in this section is adapted:

An attitude is '*a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour*' .

Each element of this definition is worth briefly examining, but the essential aspects are:

- that an attitude can be said to exist when an individual evaluates an object (the 'entity', also known as the 'attitude object') and
- this evaluation is expressed (the '**response**').

Examples given below will help to clarify this concept, but it should be noted at this stage that a response has both a **direction** (such as favour/disfavour, approach/avoidance, or approval/disapproval) and an **intensity** (weak/strong). In addition, the response can occur in any or all of three domains: **cognitive**, **affective** and **behavioural**.

It is not possible for a third party, without prior knowledge, to infer the existence of an attitude if it is not expressed.

The term 'entity', from within the definition, needs further clarification: it refers to anything that is the **stimulus** for an attitude. This may include almost anything that can be both *differentiated* and *evaluated*.

Examples are:

- Discrete entities such as an individual patient, a disease or a state of health, and classes of entities such as patients requesting termination of pregnancy or dying patients;
- Behaviours such as smoking, and classes of behaviours such as encompassed by the term 'lifestyle';

- Social policies (e.g. free prescriptions for those on income support); ideologies (e.g. the Third Way); and social groups (e.g. Turkish refugees) etc.
- Classes of entities can also include a disparate group of objects all denoting one thing, such as a ward name, a white coat and a league table that are all linked to your place of work.

This definition of attitude encompasses the concept of **values** as being attitudes towards entities that are relatively abstract, such as the goal of a 'state of freedom'. Contrast this with **beliefs**, that are assumptions about reality.

Note that the existence of an attitude is likely to be most obvious to the onlooker when a class of stimuli co-vary with a class of responses in an individual i.e. when a set of stimuli provoke a consistent and predictable set of responses.

The following exercise contains a number of important lessons for better understanding this definition of attitude, so I will spend some time outlining what these are. At various stages throughout there are opportunities for you stop and consider aspects of the example.

Activity 2

A female General Practitioner, who holds a pro-life attitude, is consulted by a patient requesting a termination of pregnancy.

⇒ What might this doctor be expected to think, and how might she be expected to feel and to behave towards this patient?

It may be that the doctor will experience feelings of discomfort and aversion (affective domain) when approached by the patient. She could respond (behavioural domain) by refusing to arrange the termination, and may explain her beliefs (cognitive domain) as part of the explanation for refusing the request (she then has a duty to refer the patient to a colleague who will consider agreeing to the patient's request). Thus to an observer (and to the patient) it would be clear from the doctor's actions, explanation of beliefs, and possibly also facial expression, that she holds a strongly unfavourable attitude towards termination of pregnancy. In this case the responses observed in all three domains cohere.

However, on this particular occasion the same doctor does not allow her feelings of aversion to show, does not explain her beliefs to the patient and agrees to arrange the termination of pregnancy. In this case, the responses do not cohere across the three domains, since

the doctor's feelings and beliefs (in this case not directly observed) are not consistent with her actions.

- ⇒ What would an observer infer about the doctor's attitude towards termination of pregnancy?
- ⇒ If the observer already knew that the doctor did indeed hold a pro-life attitude, what conclusions might be drawn by the observer?

One conclusion could be that this attitude is not strongly held (i.e. the intensity of the doctor's evaluation of the pro-life position - her attitude - is approaching neutral). However, as is perhaps more likely in such cases, it could also be that, despite quite strongly held views on termination, other factors in this *particular* situation (for example, the degree of emotional pain suffered by the patient through being pregnant) were more influential on the observed responses than was the internal attitude. This balance of influences, external and attitudinal, was then reflected in the doctor's behaviour. To acquire an accurate representation of this doctor's *general* attitude towards termination of pregnancy it may be necessary to observe her over time and across several consultations in which the request termination is made.

- ⇒ What is the difficulty with just asking the subject what her attitude is (may be more difficult for some attitudes than for others)?

In summary, attitudes may sometimes profoundly influence behaviour, but so also may other factors. Attitudes, as they are expressed, are therefore **context-sensitive**. Unfortunately they cannot be measured directly.

We shall explore the crucial relationship of attitudes and behaviour in more depth below, but it would seem reasonable to suppose that **the more strongly held the attitude the more likely it is that responses in the different domains will cohere.**

Section 3 The Duties of a Doctor

The General Medical Council (GMC), in its list of *Duties of a Doctor*, gives us guidance on how we should behave towards patients.

- For this section you will need to look at a copy of *Good Medical Practice* (GMC, 1998) and have the list of *Duties of a Doctor* to hand. This can be found at: <http://www.gmc-uk.org>
- You will also need to read: Smith R. Medicine's core values. *BMJ* 1994;309:1247-8.

Read through the *Duties* and the *BMJ* article. Implicit in these lists of *Duties* and core values are that the interaction between doctor and patient is moral in nature. By this I mean that it is governed by practitioner characteristics or conduct relating to right and wrong, as exemplified by terms such as 'respect', which itself suggests an attitudinal approach. The link between attitude and behaviour will be further explored in the Section 6, but for now consider the following:

Activity 3

⇒ Do you agree with all the *Duties of a Doctor*?

⇒ How are the *Duties* to be carried out in practice?

Some may take a 'Ten Commandments' approach to the *Duties of a Doctor* i.e. pick and choose which of them suits us at any given time and ignore the rest as unworkable or irrelevant. I do not advocate such an approach, acknowledging that, just as with the law, these are the terms of the agreement to which we have 'signed up' in becoming a doctor in the UK. This is not to say, however, that, again just as with the law, we should not question the *Duties* or the basis on which they were developed.

For example, how are we to make the care of the patient our first concern? Do we always put the patient's well being always above our own or only sometimes? Does this imply that we should be available to our patients twenty-four hours a day, seven days a week? Does this mean that the last patient on the theatre list should not be cancelled, even though it is now well past the time when the list should have been finished? Or does it imply that there

are times when we should say no, in order that at other times we are at our best. Perhaps it simply applies only to when we are at work or 'on duty' (but for GPs, the terms of their General Medical Services contract give them twenty-four hour responsibility)? It is far from clear what the acceptable boundaries are.

The problem here is that the list of *Duties of a Doctor* is not specific enough about exactly what is a doctor's responsibility to her or his patients, as the above paragraph illustrates: what are the boundaries? This same accusation has been applied to the profession's attempt to delineate its core values (only more so), prompting the comment that all that has been produced is "a list of good things that, we might hope, would be associated with any upright citizen" (Downie et al, 2000), and not a statement of inherent or defining characteristics of the profession.

Be that as it may, the GMC's guidelines are those on which we must base our practice. For more information on specific guidelines for undergraduate teaching, postgraduate training and your responsibilities as a teaching doctor, see the GMC website for the documents "*Tomorrow's Doctors*", "*The New Doctor*" and "*The Doctor as Teacher*" and related documents.

Section 4 Judging attitudes

It seems that many of the GMC's *Duties of a Doctor* are based on the clinician having an appropriate professional attitude. This appears to be an important driving force in the achieving of appropriate professional behaviours. However, behaviour, as we have seen above, is only one domain of the expression of attitude: attitudinal responses are also commonly expressed cognitively.

Activity 4

Consider the following:

- ⇒ In any given clinical context, are 'correct' attitudes always necessary for 'correct' behaviours to occur?
- ⇒ Are some attitudes so extreme in their unacceptability that, even in the absence of attitude-consistent behaviours, they warrant intervention?

This has important bearing when considering our role as facilitators of others' appropriate behaviours: should we be concerned only with behaviours, or with cognitively-expressed attitudes as well? And if we teach our students to be non-judgemental towards patients, as seems to be implied in *Duties of a Doctor*, where does our 'judgement' of students and juniors come into the facilitating of their professional attitudes, as expressed both cognitively and behaviourally?

Consider the following examples in activity 5, which may serve to illustrate both the difficulty and the importance of this issue:

Activity 5

A male student, who comes from another country, is studying at a UK medical school. When asked to comment on a clinical scenario about a rape victim he states that she deserved to be raped, because the woman in question was wearing a short skirt at the time.

- ⇒ Does this student's apparent attitude matter?
- ⇒ If so, what are the concerns that his attitude raises?
- ⇒ What if he were to assure you that his behaviour, while in the UK, will comply with UK law and with the *Duties of a Doctor* (in this case that he would behave with, for example, respect towards a future rape victim with whom he has professional contact)? Would his attitude matter then?
- ⇒ What should be the response of the tutor in this scenario?

A further example:

A male medical student confides in a fellow student that he is anxious about a forthcoming paediatric attachment because he is sexually aroused by children. The fellow student tells this to the appropriate medical school Sub-Dean.

- ⇒ What should the Sub-Dean do?
- ⇒

Both of these examples raise difficult issues about how seriously we should take attitudes when these are expressed cognitively, as opposed to behaviourally. Take the first case: here we are dealing with a student, not a practising doctor, and thus we have the opportunity to challenge his attitude and (in theory at least) to observe him in subsequent months and years to ensure that his approach to patients is consistent with the GMC's guidelines and with the law, and if not, not to allow him to graduate. Ways in which inappropriate attitudes might best be challenged will be discussed in Section 7, for now it is enough to simply note that it seems clear that such attitudes *do* need to be challenged. This necessarily requires the student to be 'judged' against the GMC's *Duties of a Doctor*; in other words, as a tutor, you are required to make judgements about your students' and trainees' attitudes in much the same way as you are required to do about their clinical competency in other areas. But note that this is explicitly **not**

treating your students and trainees as you would usually treat your patients.

The second case has the added issue of the protection of children. One approach in this case might be to persuade the student to leave medical school and to seek appropriate help. The point here is that the gravity of the potential behaviours (the behaviours that would, if they occurred, be consistent with the attitudes expressed cognitively) is a factor in determining our response. On the one hand is a student 'at risk' of disrespecting a future rape victim, on the other a student who may sexually abuse a child. In the first case, I would contend, it may be appropriate to challenge and observe, in the second this would not be appropriate. The extent with which you agree or disagree with this analysis will depend in part on your own assessment of the relative gravity of each potential behaviour.

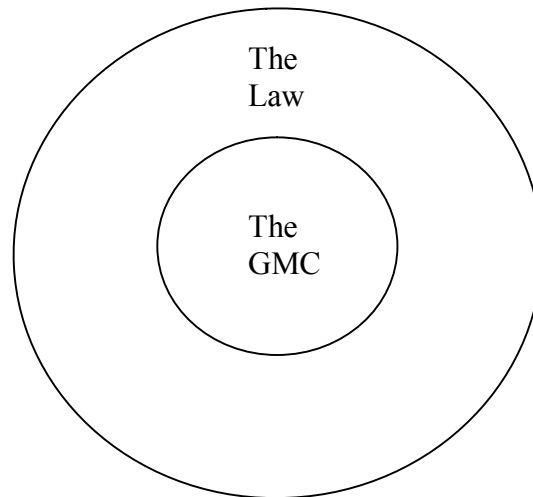
In either case, **documentation** for future reference is key. This point will be further explored in Section 7.

However, when dealing with attitudes expressed only cognitively, there remains a danger that we are somehow being asked to act as 'thought police': a problem that does not seem to apply to judging behaviours. Perhaps one way in which to achieve an acceptable balance when acting on attitudes, however expressed, is to examine your own attitudes, which is what we shall turn to next.

Section 5 Your own attitudes

Activity 6 Your own attitudes

The relationship between the law and the GMC's professional guidelines can be shown as below:



This simple model illustrates the fact that everything contained within the GMC's professional guidelines is within the law, but that the reverse is not true.

For each of the following six behavioural statements decide:

(a) where they would lie on the above diagram;
(b) what your own attitude is towards the behaviour (in terms of whether you would fully tolerate the behaviour in yourself or others, whether you would not tolerate it, or whether you are unsure):

- a. Accepting money as a gift from a grateful patient.
- b. Sexual relationships between two consenting adults, one a doctor and the other the doctor's patient.
- c. Sexual relationships between two consenting adults of the same gender.
- d. Cannabis smoking.
- e. Cannabis smoking by medical students.
- f. Cannabis smoking by MS patients to alleviate muscular spasm.

Activity 6a

Once you have completed the exercise, reflect and make notes about the following:

- ⇒ If any of your responses are not consistent with the expectations of either the law or the GMC's professional guidelines, do you think this attitude affects the way you behave in relevant contexts?
- ⇒ If not, why not?
- ⇒ Would your expressed response be different if you had to repeat the exercise in front of: your friends; your peers; the GMC's Professional Conduct Committee?
- ⇒ If so, what factors are influencing your expressed response in addition to your own attitudes?

In the decision to act on what you judge to be inappropriate cognitively or behaviourally expressed attitudes in others, it is important to bear in mind some 'balancing' propositions:

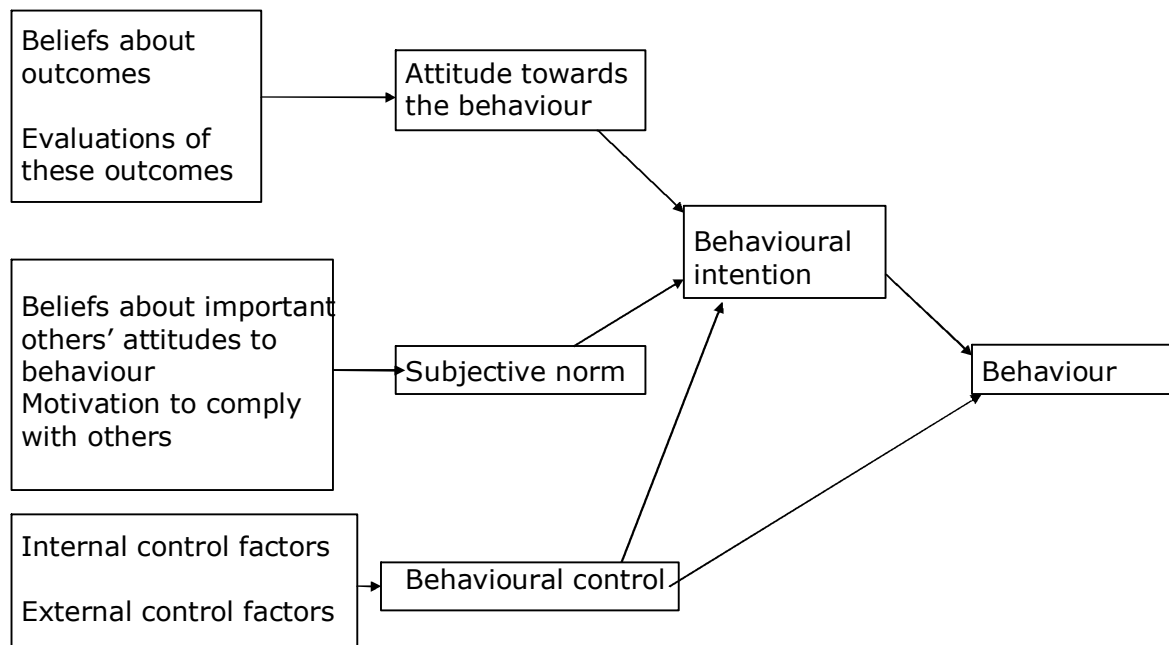
- That there may be many factors influencing this instance of an expressed attitude (this brings us back to the issue of context-sensitivity).
- That cognitively-expressed attitudes do not always result in consistent behaviours.
- That your own attitudes may not always be consistent with the expectations of the law or professional guidelines, even if your behaviours are.
- That the very act of intervening in the arena of attitudes is predicated on the assumption that attitudes can change (it is not difficult to think of examples in our own lives where this is indeed the case).

Section 6 Attitudes and behaviours

In this section we shall consider the link between attitudes and behaviours. We have already begun to see that attitude is only one influence on behaviour, and hopefully you will have come up with some others, such as the expectations of those around you. How can we make sense of these factors in a useful way?

At this stage it is useful to examine one of the models that have been proposed to explain the relationship between attitude and behaviour: Ajzen's (1988) theory of planned behaviour (TPB), (see also Ogden, 1996) In this theory there is an *intention* step in the cognitive processes that are part of the chain of processing leading to a behaviour. Various factors influence this step, including attitudes, but also aspects of subjective or social norms for the behaviour and other behavioural controls.

For those interested in exploring this theory in more detail this Diagram of the Theory of Planned Behaviour gives a diagrammatic representation of the TPB.



This theory emphasises an *intention* step occurring between beliefs and actual behaviour. This intention step is influenced by:

- *the attitude towards a behaviour* (being composed of both a belief about the behaviour and an evaluation of the outcome)

- *subjective norms* (perception of others' attitudes to behaviour and motivation to comply)
 - *behavioural control* (belief, based on past behaviour, about whether or not the individual is capable of carrying out the behaviour - this belief also acts directly on the behaviour)
-

The importance of the TPB for us lies not in the detail but in its recognition of the influence of the social context in which attitudes are expressed: context-sensitivity. Of course, it is difficult to see how this cognitive process would have time to occur in certain situations where the behaviour is a reflex reaction, such as burning your hand on an iron. But certainly you may be aware that, on some occasions at least (perhaps while completing activities 6 and 6a in Section 5, for example), there is a thinking stage about whether or not to undertake the behaviour.

What might these other social influences on behaviour be? Several factors have been postulated to potentially influence actual behaviour in addition to attitude. Examples are (Gross, 1992):

- the individual's perception of the immediate consequences of the action
- perception of how others will evaluate actions
- habitual responses
- situational factors, for instance the circumstances of a third party
- pressure to conform

Activity 7

Consider the following:

- ⇒ What is the implication of context-sensitivity for the formal assessment of attitudes?
- ⇒ In particular, what factors may influence a trainee's responses to a questionnaire about his or her attitudes?
- ⇒ If questionnaires are particularly open to response biases due to the influence of social factors, how else could attitudes be assessed (see Section 8)?
- ⇒ What positive and negative factors in medical education might influence trainees' attitudes? Break down your answer into trainee, tutor and institutional factors (for instance, have you ever made disparaging comments to your students about doctors from a different speciality to your own?) - this will be covered in the next section

Section 7 Responding to problematic behaviours

For this Section please read the following papers:

1. Burack JH, Irby DM, Carline JD, Root RK, Larson EB. Teaching compassion and respect: attending physicians' responses to problematic behaviors. *J Gen Intern Med* 1999;14:49-55.
2. Doyal L. Closing the gap between professional teaching and practice. *BMJ* 2001;322:685-686.
3. Hicks LK, Lin Y, Robertson DW, Robinson DL, Woodrow SI. Understanding the clinical dilemmas that shape students' ethical development: questionnaire survey and focus group study. *BMJ* 2001;322:709-710.

It is likely that many of the problematic behaviours we see from time to time in our students and juniors (not to mention senior colleagues) arise from what could be considered inappropriate attitudes. This being the case, how should we, as facilitators of our trainees' professional attitudes, respond? Clearly, judging by the above papers, the most common response is to ignore the behaviour. Equally clearly this amounts to an abdication of our responsibilities.

Activity 8

- ⇒ List the ways in which we can respond to problematic behaviours / attitudes
- ⇒ Which of these are the most practical?

Read through the following extracts

Document 1 - Possible influences upon the development of professional attitudes

Tutor factors:

- Knowing and practising acceptable behaviours
- Identifying unacceptable behaviours

- Role modelling (both at the bedside and in the corridor)
- Non-humiliation in teaching
- Mentoring
- Reflective practice
- Effective feedback

Course & Institution factors:

- Communication skills training
- Ethics teaching
- Humanities papers
- Use of moral philosophers, social scientists, lawyers, patients and carers
- Use of story and anecdote
- Assessment and grading opportunities
- The hidden curriculum (for more information on this important concept see: Hafferty FW, Franks R. The hidden curriculum, ethics teaching and the structure of medical education. *Acad Med* 1994;69:861-71.)
- School leadership
- Biostatistical v psychosocial focus

See also **UTL 2 Curriculum design and development** for more on the hidden curriculum and **UTL 8 Ensuring equality of opportunity in teaching and learning** for more about these topics

Student factors:

- Personality
- Genetic predispositions
- Maturity

Document 2 - Practical steps for responding to problematic behaviours and attitudes

1. Seek evidence of insight
 - a. Is the trainee aware that their attitude or behaviour is unacceptable and unprofessional for someone wanting to be a doctor in the UK?
 - b. Is there insight into the possible or actual effect of their attitude/behaviour on the patient?
 - c. What are the reasons for saying what was said, or for behaving in the way in question?

2. Specific feedback

- a. This should be given as soon as possible after the event.
- b. In retrospect, what did the trainee think about what was said/done?
- c. What is your view of what was said/done?
- d. Ensure use of specific examples of the behaviour and/or verbatim quotes of what was said, if possible.
- e. Do not criticise what cannot/should not be changed (for example, "the way you express your religious beliefs is offensive to some of your patients because...." is to be preferred over: "the problem is your religious beliefs").

3. Reference to social, legal and professional norms

- a. This requires you to be aware of what these are!
- b. Show how the particular attitude or behaviour contradicts acceptable practice.
- c. Identify in your own mind your particular prejudices, and consider the influence of these on your actions.

4. Encourage (and model) reflective practice

- a. To be effective this should be a routine part of your own practice, but requires a degree of openness which some may find unfamiliar and threatening.
- b. We all have encounters with patients that do not go as well as they should, for various reasons. These provide excellent opportunities for you to be explicit about your reflective thinking after such an encounter.
- c. Anecdotes about such encounters are effective for this purpose, not just making use of those observed by the trainee.

5. Look for underlying problems

- a. Are there any extenuating circumstances for the attitude/behaviour?
- b. In particular, be aware of the pastoral needs of your students – could this instance of inappropriate behaviour be a signal of an underlying problem that requires further attention in a different context e.g. counselling.

6. Document

- a. This is of vital importance if inappropriate attitudes do not improve and need to be acted on at a later date – without such a 'paper trail' this would be difficult.
- b. Documentation needs to be collated centrally – contact medical school administration or Royal College.
- c. Share your documentation with the student/trainee, who should be allowed to disagree, in writing, with your view (although this should not be a reason for withholding the documentation).

7. Seek further help

8.

- a. This is necessary in some circumstances, and may depend in part on the degree of inappropriateness of the attitude or behaviour, or on its affect on patients or colleagues.
- b. Ensure you know, or know how to find out, who are the appropriate personnel within your institution e.g. who is the medical school Dean responsible for pastoral care of students?

9. Look for evidence of change

- a. Document this.
- b. It may require cooperation across training disciplines, in which case it should be the responsibility of those in central control of training. This does not imply that future tutors should always be 'warned' about particular individuals; be aware of the influence of 'personality clashes'.

Activity 9

⇒ Note your response to the contents of the documents?

⇒ How practical do you think it will be to implement these ideas?

Section 8 Assessing attitudes

All of the above suggestions regarding documenting and acting on inappropriate attitudes are based upon the idea that we are able to assess these against professional standards. This raises a number of issues, but some US medical schools have implemented formal mechanisms for doing so. In both of the following papers the primary method utilised for assessing attitudes in medical students is the observation of behaviours.

Examples of these are contained in the following papers:

1. Phelan S, Obenshain SS, Galey WR. Evaluation of the non-cognitive professional traits of medical students. *Acad Med* 1993;68:799-803.

2. Papdakis MA, Osborn EHS, Cooke M, Healy K, University of California, San Francisco School of Medicine Clinical Clerkships Operation Committee. A strategy for the detection and evaluation of unprofessional behavior in medical students. *Acad Med* 1999;74:980-990.

At the level of research a number of methods are used: self-completed questionnaires; clinical vignettes or 'paper cases'; and observation.

Each of these has strengths and weaknesses, as summarised in the table below:

Methods	Strengths	Weaknesses
Questionnaires	Low cost; Ease of use; Reliable.	Susceptibility to response bias; Low validity.
Clinical paper cases	Low cost; Ease of use.	Still susceptible to response bias; More face validity than questionnaires.
Observation of behaviour	High face validity in real clinical settings, less in examination settings; Less susceptible to response bias.	Reliability dependent on inter-observer error and number of samplings (high number needed); Expensive in terms of observer training and time; Likely to be time consuming to apply.

It may be useful to clarify some terms:

- Reliability and validity : a useful guide to the many permutations of these terms can be found in:

Barker C, Pistrang N, Elliot R. *Research Methods in Clinical and Counselling Psychology*. Chichester: Wiley; 1994.

See also **UTL 3 Assessment** and **UTL 7 Introduction to educational research** for more about these concepts

- Cost relates mainly to usage rather than development
- Ease of use relates to the simplicity of application of the method – an important element of overall feasibility of use
- Response bias refers to the ease with which students can adapt their responses to say what they think the examiners want to hear (i.e. the context in which the responses are given) in order to present themselves in a favourable light – called social desirability

More information regarding these methods, together with an overview of teaching attitudes, may be found in:

Martin J, Lloyd M, Singh S. Professional attitudes: can they be taught and assessed in medical education? *Clin Med* 2002;2:217-23.

Activity10

Consider the following:

- ⇒ Why are questionnaires less valid than observation of behaviour (it is not just a question of response bias)?
- ⇒ What problems are likely to arise when attempting to apply an observational method such as used at the University of San Francisco (paper 2 above) at your own institution?

In the UK there are few suggestions by the GMC about the practicalities of how to apply the *Duties of a Doctor* as a gold standard for this purpose. Given the limitations of both the research methods themselves, and the feasibility of applying them, this leaves us in the less-than-satisfactory position of basing our assessments of trainee attitudes on our own, possibly limited, observations of, and discussions with, them. In many ways this is a

similar situation to that of assessing clinical skill competency until the fairly recent advent of more reliable methods for doing so, such as Objective Structured Clinical Examinations. This does not mean, however, that we should not continue to assess attitudes using the *Duties of a Doctor* as guiding principles, whilst being as explicit as possible about the reasoning by which we, as facilitators and tutors, arrive at our conclusions.

The GMC itself uses observation (both direct and via the interviewing of patients and peers of the doctor) as part of its Performance Procedures, as does the National Clinical Assessment Authority (see Section 14). However, details of the exact ways in which observation is translated into judgements against gold standards are unclear.

FACILITATING PROFESSIONAL DEVELOPMENT

Section 9 Introduction to facilitating professional development

So far in this paper we have concentrated on facilitating professional attitudes in our students and juniors, covering aspects of the importance of attending to this area, highlighting some of the difficulties in making judgements about attitudes, and suggestions of how to go about challenging inappropriate attitudes and behaviours.

Now we shall move on to a general approach to facilitating professional development. I shall, from now on, usually refer to juniors rather than students. However, while many of the issues described here are of a postgraduate nature, there are nevertheless aspects of professionalism that are relevant to the student.

Activity 11

As with professional attitudes, reflect on the following statements and (a) note the *reasons* why you agree or disagree with each, and (b) consider in what ways each is potentially important to you as a facilitator of others' professional development.

- ⇒ Professional development is not just the responsibility of the individual, but also of the institution in which that person works
- ⇒ We are under a moral obligation to continue to develop professionally throughout our careers
- ⇒ The ultimate beneficiary of professional development is the patient
- ⇒ Professional development involves change

In this post-modern age, where there is increasing ambiguity of roles, increasing pressure of work and increasing accountability, professional development is not only an externally imposed requirement, it is also a means by which we may cope with these pressures. It is a way of ensuring that our approach to lifelong learning makes best use of available opportunities and is best targeted to our learning needs. One issue here is that of stress

some is required in order to motivate the changes that come with developing, but too much is de-motivating. You will need to consider how best to help your trainees achieve the balance of stress that will best help them learn.

Section 10 - Definition of professional development

The following definition is an adaptation of one designed for the school context by Professor Chris Day (1999):

Professional development in medicine consists of 'all natural learning experiences and those conscious and planned activities which are intended to be of direct or indirect benefit to the individual, group or hospital/general practice and which contribute, through these, to the quality of patient care and education in the clinical context. It is the process by which, alone and with others, healthcare professionals review, renew and extend their commitment as change agents to the moral purposes of medicine (including teaching); and by which they acquire and develop critically the knowledge, skills and attitudes essential to good professional thinking, planning and practice with patients, trainees and colleagues through each phase of their clinical careers.'

The definition makes the following points:

- That we should be making explicit use of 'natural', opportunistic learning experiences as well as those we plan for
- The beneficiaries of these learning experiences are not only ourselves but also our institutions and ultimately our patients
- Professional development involves change and is morally driven i.e. we must continue to develop our professional knowledge, skills and attitudes because we *should* do so
- Professional development is a life long process, and should be adapted for the stage of career of student / trainee / self

Activity 12

Consider the following:

- ⇒ To what extent should you be responsible for planning the professional development of your trainees?
- ⇒ What are the negative aspects of trying to influence developmental change in your trainees (for example, loss of ownership of their own development)?
- ⇒ How can these negative aspects be overcome?

Section 11 - Lifelong learning

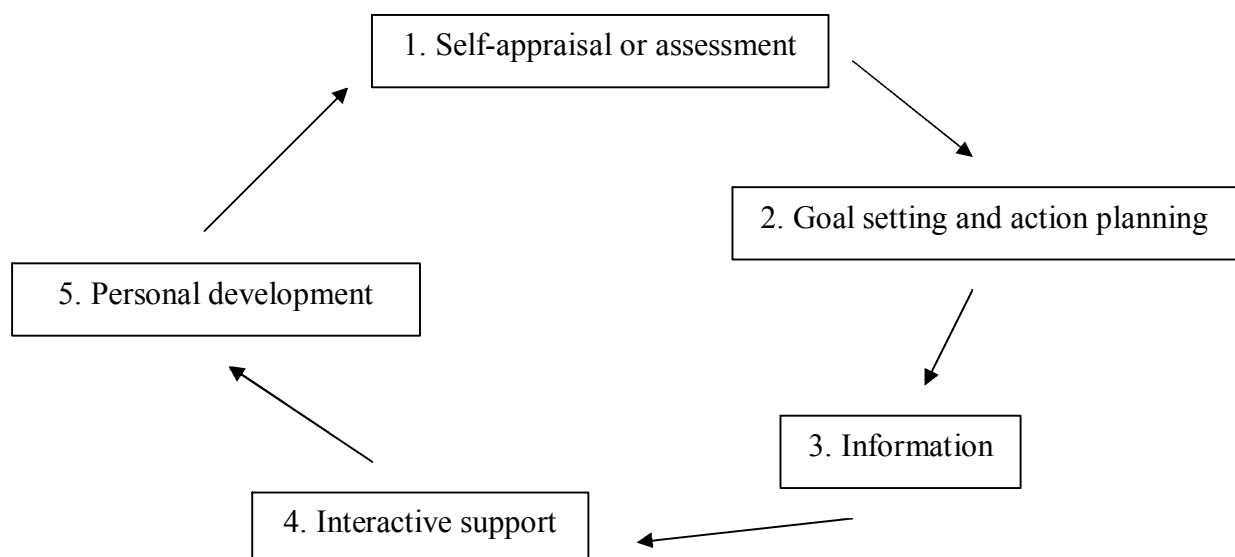
One effect of the above definition is that it helps us to consider the reasons why some people seem better at attending to their professional development needs than others. For instance, it might be that some have difficulty in engaging in their professional development (and perhaps also, therefore, in furthering their careers) because the way in which they best learn is not met by available teaching or because of the institutional systems within which they operate.

Activity 13

⇒ Think about what motivates your own professional development. Structure your ideas in terms of personal motivators and external motivators.

⇒ What else could motivate other people?

Lifelong learning can be considered as a cycle:



Adapted from: Jane Falk-Whynes, Nottingham University

The cycle can be entered at different points for many reasons, including the personal and external reasons you thought of in exercise 13.

Part 1 – this is either carried out alone, or is facilitated by you. Either way it requires, on the part of the trainee, the capacity for reflection.

Part 2 – the important consideration here is that the goals are relevant, understandable, achievable and measurable.

Part 3 – the trainee may require help with finding out where to go to gain the knowledge or skills necessary to achieve the goals. It is not your job as facilitator to be the provider of the knowledge or skills, although it may be that you wish to do so. A good place to start looking are the various Royal College websites, which should also give guidance about the sorts of goals that trainee should be aiming for, based on the what it takes to be competent in the different disciplines.

Part 4 – you should be one, but not necessarily the only, source of support for your trainees. Bear in mind, however, that the locus of control for lifelong learning should remain with the trainee.

Part 5 – this has to do with change. The advantage of measurable goals now becomes clear. What are the outcomes of this process? What has your trainee learned and what effect has this had on his or her practice? How will your trainee integrate new knowledge or skills?

Activity 14

Consider:

- ⇒ How does the trainee get back to the beginning of the cycle again, and what is your role in this?
- ⇒ How often, and at what specific points in training, should Part 1 be carried out?

Activity 15

The British Dental Association
Personal Action Planning

Introduction

This sheet is designed to offer a guide for your thoughts as you plan your future activities.

It may be a useful discipline to fill in the form rather than just to talk around the headings, but, however you choose to use it, it is suggested that when you have worked through the questions you discuss your ideas with a colleague.

My next/final (delete one) objective is

.....
.....

The actions/steps I need to take in order to achieve this are:

1.
2.
3.
4.
5.
6.

The things that may make my objective difficult to achieve are

.....
.....
.....

Some of the things I could do to minimise their effects are

.....
.....
.....
.....

People who could help me are

.....

I can enhance my chances of success by

.....
.....
.....
.....

The timescale for my action is:

By the end of today I will

By the end of tomorrow I will

By next week I will

By next month I will

Six months from now I will have

.....

After one year I will have

Measurable progress – I will know that I have succeeded when.....

.....
.....
.....

Section 12 - Expertise, reflection and professionalism

Consideration of issues to do with the nature of expertise and of being a professional, as well as an understanding of reflection, will be useful to you as a facilitator of professional development.

Expertise

Activity 16

Consider:

⇒ What is the difference between expert and novice?

Some of the answers to the above question could include:

- Experts bring knowledge and skills to bear in better ways than novices
- Experts do so in less time (they are more efficient)
- Experts have insight and can bring novel but appropriate solutions to bear on a problem
- Experts develop intuition: expert guessing

One theory, the Dreyfus Model of Skill Acquisition (Dreyfus & Dreyfus, 1986) suggests that learning from experience is key to developing expertise, although theoretical learning and the development of fluency in standardized tasks is also important. Whereas the novice will tend to adhere rigidly to rules or plans, with no discretionary judgement, the competent person is able to use routinised procedures, and is able to see actions at least partially in terms of longer-terms goals.

The Dreyfus Model of Skill Acquisition (simplified)

Novice	Adheres to rules No discretionary judgement
Competent	Copes with crowded situations Routinized procedures Sees longer-term goals
Expert	Apprehends situations more deeply Behaviours are semi-automatic Divergent situations quickly spotted and acted upon

To go beyond competence is to begin to apprehend situations more deeply, for behaviours to become semi-automatic, and for the abnormal, 'divergent' situations (in terms of variation from the expected) to be quickly spotted. The expert no longer relies on rules or guidelines but has a more intuitive approach to situations based on deep tacit understanding. Where novel situations or problems arise a more analytical approach is taken. The expert is capable of vision.

For the expert, therefore, the divergent situation is key since it is this that is the trigger to bringing a non-semi-automatic approach to bear. Where there is no variation from the expected the semi-automatic approach suffices, and is the most efficient.

Activity 17

Consider:

- ⇒ Given this kind of model of expertise, what are implications of shorter training periods?
- ⇒ How could this model help you to facilitate the professional development of your trainees?

These issues are developed further in chapter seven of the book:

Eraut M. *Developing Professional Knowledge and Competence*. London: The Falmer Press; 1994. This chapter contains a useful

critique of Donald Schön's theories of reflective practice, to which we now turn.

Reflection

In his famous book, *The Reflective Practitioner* (1983) Schön picks up on this issue of divergent situations and it is on these that he concentrates, rather than the unproblematic aspects of professional work.

The key concept is "reflection-in-action". This is triggered by the recognition of a divergent situation and asks the critical questions: what is this, and how have I been thinking about it? This second, metacognitive question, may allow for a reframing of the problem, and has an immediate effect on action. It is, Schön believes, an example of the artistry of the expert.

The expert is able to go around the cycle of reflection-in-action to new action to further reflection-in-action both quickly and frequently in a single consultation. The trainee is less able to do so, and is more likely to spend the time necessary for reflection after the event. This is a second form of reflection, also used by experts: "Reflection-on-action". This is the making sense of an action after it has occurred, possibly learning from experience and extending one's knowledge base, possibly affecting future actions. However, whereas the expert may undertake reflection-on-action spontaneously, the trainee may require help to do so.

Activity 18

Consider the following:

- ⇒ If time is short, what happens to reflection-in-action?
- ⇒ How could you help develop reflective practise in your trainees (for example, by verbalising your own reflection-on-action)?

An interesting problem for the developing health care professional, one solved partly by reflecting on the nature of the doctor-patient relationship, has been put succinctly by Professor Roger Higgs (1997): "For the doctor, the need to generalise professionally also contains the 'same case, different face' trap" .

- ⇒ What do you think he means by this?

He goes on to suggest that the solution to this problem lies in the transient, but genuine, relationship between doctor and patient, thus echoing both some of the issues we have covered in dealing with attitudes, and linking us neatly with issues of professionalism, to which we shall turn next. He goes on to say: "It is our moral perspective that supplies the understanding of the unique value of each individual".

Professionalism

"Medicine must always be treated as a public good, never as a commodity" Sullivan (2000)

In this part we shall take a brief look at the nature of a profession, and the impact of being healers on the concept of professionalism. For those wishing to explore further, a fuller account of the issues can be found in the following paper:

Cruess RL, Cruess SR. Teaching medicine as a profession in the service of healing. *Acad Med* 1997;72:941-52.

Activity 19

Consider:

⇒ What are the characteristics of a profession?

Read also:

1. Cruess SR, Cruess RL. Professionalism must be taught. *BMJ* 1997;315:1674-7.
2. Sullivan WM. Medicine under threat: professionalism and professional identity. *CMAJ* 2000;162:673-5.

Activity 20

So:

⇒ How does the healing nature of our work interact with being a professional?

⇒ Why does professionalism need to be taught?

⇒ How can it be taught?

Section 13 - Mentoring and role modelling

The teaching of medicine has traditionally been one based on an apprenticeship model. As this has declined and the curriculum for medical education become more formalised, so the need for identifiable mentors has increased. Your role as facilitator of the professional development of your trainees is likely to include that of being a mentor.

To learn more about mentoring and how it applies to clinical teaching situations go now to the mentoring section in **UTL 6 Educational supervision, personal support and mentoring**

Definitions of mentoring are many, as are the descriptions of what it is a mentor should actually do. Most agree that mentoring should be informal, separate from assessment (this is debated), and confidential. There are debates also as to whether mentors need to be trained for the purpose, or simply empathic individuals with characteristics such as understanding, a caring nature, enthusiasm and an ability to encourage (Alliot, 1996). Traditionally the mentor has an overseeing role, concerning aspects of the trainee's education, and personal and professional development, including career advice.

Read: Grainger C. Mentoring – supporting doctors at work and play. *BMJ* 2002;324:S203

An additional and useful paper for those wanting to take this further is a literature review of clinical supervision:

Kilminster SM, Jolly BC. Effective supervision in clinical practice settings: a literature review. *Med Educ* 2000;34:827-40.

The definitions of clinical supervision in this paper seem to share many characteristics with that of mentoring, and the authors note that:

- Supervision has three functions: educational, supportive and administrative
- There is evidence that supervision has a positive effect on patient outcome
- The quality of the relationship between supervisor and trainee is the single most important factor in determining the effectiveness of that supervision

For more on educational supervision go now to the educational supervision section in **UTL 6 Educational supervision, personal support and mentoring**

Now read: Paice E, Heard S, Moss F. How important are role models in making good doctors? *BMJ* 2002;325:707-10.

Activity 21

- ⇒ How do role models differ from mentors?
- ⇒ Which of the characteristics of a good mentor do you possess?
- ⇒ Which of the characteristics of a good role model do you possess?
- ⇒ What is the link between mentors and role models for professional development on the one hand, and teaching professional attitudes on the other?
- ⇒ How can you influence the quality of role models in your institution?

Useful links

This final Section on professional development will give links to several sites of use to the trainee or facilitator. Inevitably, when considering professional development, the issue arises of what to do if a doctor is failing to meet the requirements of *Good Medical Practice* (GMC, 1998). For this reason I will also briefly discuss the role of the GMC and other organisations of relevance to this.

Personal Development Plans (PDPs)

The key phrase is 'Personal Development Plan'. It is a good idea to complete one of these, which can form the basis for appraisal, revalidation and an educational portfolio. A good place to start is Roger Charlton's review of the topic:

Charlton R. Personal development plans (PDPs). *BMJ* 2002;325:S36.
<http://bmj.com/cgi/content/full/325/7358/S36>

For GPs, but adaptable for others, there is an abundance of downloadable PDP forms from:

<http://www.londondeanery.ac.uk/gp/home.htm>

Royal College requirements

It is essential that you know both what your trainees are supposed to know and what they are supposed to be doing in terms of professional development. Check your Royal College website for details.

The GMC and other organisations

<http://www.gmc-uk.org>

The GMC is not a general complaints body and can only act where there is a question about a doctor's fitness to practise.

1. Appraisal and revalidation:

The GMC supports the plans of the NHS to bring in appraisal, in the form of an annual review, for all doctors wishing to practise medicine in the UK. Revalidation, currently particularly targeted at GPs but eventually for all doctors in the UK, will occur on a five-yearly cycle and will signify that the GMC is satisfied that the doctor remains fit to practise medicine (usually a summary of the annual

appraisals will be enough for this purpose). For more information visit:
<http://www.revalidationuk.info/>

2. Performance procedures

The GMC has the power to assess your professional performance through a process of inquiry (as opposed to issues of professional conduct that are dealt with through the Professional Conduct Committee) if your performance appears to be seriously deficient. From this they make recommendations about action needed to rectify the deficiencies and can suspend your registration if necessary. The process is summarised on the GMC's website, but includes visits to the doctor's place of work to review records and to interview her/his colleagues and others. It also includes observing consultations, and although their literature talks only in terms of knowledge and skills, it is likely therefore to include attitudinal aspects also.

3. Clinical governance

The GMC is working with the Commission for Health Improvement (CHI) on issues relating to clinical governance. Where this affects the individual doctor is if a clinical governance review or investigation raises concerns about the doctor's fitness to practise. Where appropriate such doctors will be referred to the GMC. A Memorandum of Understanding between the GMC and CHI is on the GMC website.

CHI can be found at:
<http://www.chi.nhs.uk/>

4. Working in the clinical setting

The National Clinical Assessment Authority (NCAA) is a Special Health Authority set up by the government as part of its plans to "ensure that patients have better protection and doctors, better support." The differences between it and the GMC are subtle in this context, but hinge on the concept of fitness to practise (responsibility of the GMC) as opposed to the practice of an individual within a team or in a clinical setting (responsibility of the NCAA). The NCAA will investigate concerns about a doctor's performance in a similar manner to the GMC. A Memorandum of Understanding between the GMC and NCAA is on the GMC website. The NCAA's own website is:
<http://www.ncaa.nhs.uk/>

5. The independent sector

Similarly, the National Care Standards Commission (NCSC) has been set up to regulate the independent sector. Again, a Memorandum of Understanding between the GMC and NCSC is on the GMC website. Their own website is:

<http://www.carestandards.org.uk/>

Summary

By way of summarising some of the issues we have dealt with during this paper, I recommend the interesting article:

Christakis DA, Feudtner C. Temporary matters – the ethical consequences of transient social relationships in medical training. *JAMA* 1997;278:739-43.

This article points out the negative effect of the transient nature of the relationships between training doctors and patients, and between trainees and other healthcare professionals, including their superiors. It gives another rationale for the importance of effective mentoring and role modelling, and highlights the need to attend to the attitudes of our students and juniors.

References

Ajzen I. *Attitudes, Personality and Behaviour*. Milton Keynes: Oxford University Press; 1988.

Alliott R. Facilitatory mentoring in general practice. *BMJ* 1996;313(classified):2-3.

Day C. *Developing Teachers: the challenge of lifelong learning*. The Falmer Press: London;1999

Downie RS, Macnaughton J, Randall F. *Clinical Judgment: Evidence in Practice*. Oxford: Oxford University Press; 2000.

Dreyfus HL, Dreyfus SE. *Mind Over Machine: The Power of Human Intuition and Expertise in the Era of the Computer*. Oxford: Basil Blackwell; 1986.

Eagly AH, Chaiken S. *The Psychology of Attitudes*. Orlando: Harcourt Brace & Company; 1993.

Falder S. Balancing medicine with a life. *BMJ* 1998;317(classified):2-3.

General Medical Council. *Good Medical Practice*. London: GMC; 1998.

Gross RD. *Psychology: Science of Mind and Behaviour*. London: Hodder & Stoughton; 1992.

Higgs R. *Shaping our ends: the ethics of respect in a well-led NHS*. *Br J Gen Pract* 1997;47:245-249.

Irvine D. The performance of doctors: the new professionalism. *Lancet* 1993;353:1174-7.

Ogden J. *Health Psychology - a Textbook*. Philadelphia: Open University Press; 1996.

Schön D. *The Reflective Practitioner: How Professionals Think in Action*. New York: Basic Books; 1983.

Sullivan WM. Medicine under threat: professionalism and professional identity. *CMAJ* 2000;162:673-5.