TRAINING

Developing medical professionalism for psychiatry trainees in the North West: A survey of trainee understanding

Adam Joiner & Sam Dearman

Introduction
The terms ‘medical professionalism’ and ‘professionalism’ are used interchangeably in the literature and definitions vary (Epstein & Hundert, 2002). However, the authors of this article would suggest that professionalism as a concept is best understood as a competence, involving a complex interaction between knowledge, skills and attitudes applied across various professional situations and contexts.

Developing professionalism at medical school has become an increasing focus of attention as outlined in the General Medical Council (GMC) document Tomorrow’s Doctor (General Medical Council, 2009). The Royal College of Psychiatrists defines professionalism as one of the three overarching domains of the core curriculum, “doctor as professional” (Royal College of Psychiatry, 2011). Professionalism is one of the six ‘essential abilities’ of a medical expert, according to CanMEDS (Frank, 2005), and so makes up part of postgraduate curricula around the world. The Royal College of Psychiatrists adopted the CanMEDS framework for the postgraduate curriculum for trainees in the UK (Royal College of Psychiatrists, 2010). By explicitly incorporating professionalism into curricula, the importance of professionalism as an attribute to develop is highlighted (Hafferty, 2008) and it is argued that teaching professionalism will reduce unprofessional conduct and disciplinary action (Papadakis, Teherani, Banach, Knettler, Rattner, Stern, Veloski & Hodgson, 2005).

Passi, Doug, Peile, Thistlethwaite & Johnson (2010) in their systematic review, in support of the development of professionalism, identify five areas for consideration: student selection, adequate curriculum design, adequate teaching and learning methods, appropriate role models and adequate assessment. The evidence with reference to the desired outcomes in terms of the teaching, learning and assessment methods is however unclear.

Using the domains for the Passi et al., (2008) systematic review a survey was conducted investigating whether or not psychiatry trainees in the North West Deanery feel they are getting adequate teaching, learning opportunities and assessment of professionalism, including access to appropriate role models. Trainees were asked whether or not they recognise professionalism as a part of their curriculum, and whether or not they felt learning about professionalism is important.

Participants and responses
Data was collected between September 2013 and February 2014 using an online survey. All psychiatry trainees in the North West deanery were invited to participate. Of 220 trainees invited there were 84 responses, giving a response rate of about 38%. There were representative responses from trainees in different aspects of mental health services including general adult, older adult, child and adolescent, learning disabilities and forensic. There were also representative responses from trainees across the various stages in training, from those new to psychiatry to those about to become consultants.

Results
The significant majority, 76% (64) of trainees felt that development of medical professionalism was part of their curriculum with 7% (6) saying no and 18% (15) saying they didn’t know. In addition 92% (77) felt that professionalism is important with only 8% (7) suggesting it was not important or they didn’t know. 63% (53) of trainees felt that there are opportunities to learn about professionalism with 20% (20) feeling that they did not have such opportunities and 17% (14) saying they didn’t know.

Most trainees felt that their supervisors were good role models for professionalism, 85% (71), with 7% (6) saying they did not feel their supervisors were good role models and 8% (7) not knowing. Interestingly the majority of trainees, 76% (64) felt that they had their professionalism assessed with 10% feeling that they hadn’t and 13% (11) saying they didn’t know.

There was a significant shift away from positive answers when it came to the actual teaching of professionalism with 74% (62) saying they didn’t receive such teaching or that they ‘didn’t know’ and 79% (66) saying that such teaching was not adequate or that they ‘didn’t know’.
Discussion
The majority of trainees felt professionalism is important and just over three quarters recognised that it is part of the curriculum. Also while all trainees will have the opportunity to learn and develop their professionalism and have their professionalism assessed, just 63% and 76% respectively recognise this. This suggests that there may be less emphasis on encouraging learning and development in medical professionalism compared to other aspects of the curriculum.

Perhaps most significantly the results suggest either a perceived or true lack of teaching available to foster learning and development of professionalism, which in the authors experience is likely to be accurate. This suggests that there is a discrepancy between the trainee’s experience of formal learning and perceived experiential learning. Therefore there is scope to address development of professionalism more explicitly and in a planned manner but at this time learning appears to be more opportunistic.

Although superficially it is reassuring that 85% of supervisors are seen as good role models for professionalism, it is also concerning that 15% were not thought of as such, and 7% were considered as definitely not good role models. This is a challenging issue for the training providers and school of psychiatry alike.

A limitation of this study is that the standards used are recommended for ensuring the effective support in developing professionalism in medical students (Passi et al., 2010), rather than postgraduate trainees. The response rate was relatively low, meaning that the results are potentially not conclusive and subject to responding bias, however a response rate of around a third is typical of postal surveys.

How can the results of this survey be used to improve the quality of the educational experience?
These results were presented at the psychiatry trainee and trainer day in October 2014, in order to generate discussion regarding recommendations as part of a workshop. It was noted in the qualitative feedback from the workshops and examples of experience that very similar themes emerged as detailed in the results of the survey. A number of developmental recommendations were suggested:

**Formal Learning Changes Recommended:**
- Incorporate case discussions (e.g. GMC fitness to practice case discussion; Waddington & Dearman, 2011) into regular teaching programmes (e.g. half a day per year);
- Offering opportunities for trainees to provide teaching/learning for medical students on placement around issues of medical professionalism and
- Peer groups to discuss professionalism issues, similar to Schwartz groups (Kings Fund, 2011; Davies, undated).

**Informal Learning Changes recommended**
- Educational supervisors taking the lead in bringing up professionalism issues in supervision and highlighting them as such;
- Seeking feedback from patients and colleagues. Discussed the possibility of using iwantgreatcare.org and
- Raise awareness of role modelling and professionalism when training educational supervisors.

**Hidden Learning Changes Recommended:**
- Increase awareness of the need to develop professionalism from the school of psychiatry and
- Increase in information, including standards, available to trainees (e.g. via website).

**Assessment changes recommended:**
- Work Place Based Assessment once per six to 12 months with focus on professionalism, or alternatively use of P-MEX (professionalism mini evaluation exercise; Cruess et al., 2006) once per year.

**Affiliations**
Dr Adam Joiner, Consultant Psychiatrist, Cumbria Partnership NHS Foundation Trust.
Dr Sam Dearman, Consultant Psychiatrist, Cumbria Partnership NHS Foundation Trust

**Contact Information**
Dr Adam Joiner. Email: adam.joiner@cumbria.nhs.uk

**References**
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REFLECTION
Promoting exercise among renal patients

Neil M. Thomas

Abstract
The following report contains a critical overview of some of my experiences during 100 hours of promoting and monitoring exercise among kidney patients at Kendal renal unit. It focuses on barriers to patient participation, the practice of exercise promotion, and finally, some considerations for safe and effective exercise.

Keywords
barriers to participation; health promotion; inter-dialytic exercise; intra-dialytic exercise; kidney disease; physical activity

Introduction
In 2014 I was given the opportunity to promote and monitor exercise among the patients at Kendal renal unit. My time there afforded me valuable experience applying evidence based theory in a clinical environment, while substantially developing my personal and professional skills. For this I express my gratitude to all the staff and patients involved. Perhaps more importantly, however, I have been able to reflect on my experiences and critically evaluate the practice of physical activity and health promotion among a renal population. The following report, I hope, offers useful information to anyone seeking to encourage exercise in their own renal environment.

Exercise for renal patients?
If you are not already familiar with exercise among the renal community, you may be wondering why on earth anybody would be promoting such an activity. Well, in recent years there has been a wealth of literature highlighting the benefits of exercising during dialysis, and/or on non-dialysis days. Some of these benefits include improved psychological wellbeing (Parsons, Toffelmire & King-VanVlack, 2006); reduced muscular atrophy and improved physical performance (Kouidi et al., 1998); reduced risk of cardiovascular disease and improved cardiovascular fitness and fatigability (Storer, Casaburi, Sawelson & Kopple, 2005; Wilund et al., 2010); and an improvement in urea clearance during dialysis (Mi Rye Suh, Hyuk Jung, Bae Kim, Sik Park & Seok Yang, 2002). Regular exercise thus may help improve quality of life, prevent further illnesses, and improve the efficacy of dialysis treatment. Of course exercise may not be for all renal patients, and in certain circumstances it may not be appropriate at all. However, considering the potential