

A Military Transitional Year Professionalism Curriculum

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Abstract

Background Development of professionalism is a critical component of a military transitional year residency. Little published research exists to guide programs in meeting this challenge.

Objective and Methods After significant concerns regarding resident professionalism were raised by Tripler Army Medical Center faculty, a novel transitional residency professionalism curriculum was conceived and implemented. Universal expectations of physician professionalism, as perceived by various stakeholders (patients, parents, faculty, and nurses), were explored using a small group, discussion-based curriculum. This was combined with a small group, discussion-based,

lessons-learned project and a military-unique curriculum.

Results Since implementation, the curriculum has had 100% satisfaction on the part of the faculty and 80% to 100% on the part of the residents, as measured by annual review surveys. Although resident professionalism scores on evaluations did not change significantly, the number of adverse actions because of professionalism lapses has decreased steadily in the 4 years since inception, and the program has been without any such actions for the past 18 months.

Conclusions Our novel transitional residency professionalism curriculum has been successful in a military residency program.

Introduction

Transitional year residencies must provide a general enough clinical experience to prepare residents for a wide variety of specialty training programs. In the military, they must also provide an experience intense enough to give a background for independent practice as a general medical officer. The end result should be a clinician professionally mature enough to take on the roles of a specialty trainee, clinic supervisor, and/or command advisor.

In our training program, it was made clear in 2008 during the annual internal review that faculty had serious concerns about resident performance regarding profes-

sionalism. These concerns were partially based on recent events resulting in dismissal of 1 resident from the program for repeated lapses in professionalism and program-level remediation for several others. Several faculty members called for a transitional year program professionalism curriculum.

Although professionalism curricula have been developed and published for many other specialties, such as pediatrics, surgery, anesthesiology, and internal medicine,¹⁻⁶ published guidelines on professionalism training for transitional year residencies is lacking. The program sought to create a novel approach to professionalism training based on how it obtained feedback on resident performance in this core competency.

Methods

Settings and Participants

Tripler Army Medical Center has a small military transitional year residency program with 10 to 14 residents per year and 14 designated core clinical faculty. Approximately one-half of the residents select the program after failing to match in their specialty of choice. These residents will either match for an alternate program in their intern year or become general medical officers at the completion of their transitional year residency. The remaining residents are preselected for residencies in ophthalmology, radiology, dermatology, or anesthesiology.

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Educational Interventions

At the time of inception, residents were solicited for ideas to improve professionalism training. One recurring theme was the notion that expectations of professional behavior were nebulous. More than 1 resident stated that they couldn't explain what professionalism is, only what it is not.

Using published literature^{2,7} and solicited faculty and resident feedback, a professionalism curriculum was developed, focusing on perceptions and expectations of the resident physician from patients, patients' families, nurses, and faculty. The impetus for this focus was the disparity of opinions regarding professional behavior expressed between these groups on prior resident evaluations and the knowledge that most programs rely on evaluations from a variety of sources to include nurses, patients, peers, and faculty regarding professionalism.⁷

The curriculum consisted of small group discussions, which were resident led but mediated by faculty, involving each of these parties. There were 4 hour-long discussions held throughout the year. Each session focused on a different group: patients, parents of patients, nurses, and consulting faculty physicians. The discussions were scenario based and used an anonymous audience response software system to allow the residents to answer a series of questions about what qualities/behaviors constitute professionalism in a physician. The patients, faculty, family members, and nurses were provided the questions ahead of time and the responses were compared and contrasted. Differences and similarities were discussed. In the course of the hour, 4 to 6 scenarios were presented and served as springboards for discussion. In the context of these discussions, the residents were able to voice areas of concern within the health care environment and were offered clarity regarding their role in the health care team and regarding patient expectations. Similarly, patients, nurses, family members, and faculty were able to voice their expectations of professional behavior from residents. Both groups were able to discuss areas and pitfalls where lapses in professionalism were likely to occur.

An example of a teachable moment that arose was in a parent's response to 1 of the scenarios about what was most important in the patient-physician relationship: (1) promptness; (2) personality (making the child laugh); (3) being a good listener; or (4) being knowledgeable. The residents universally selected "4" to that question. Most parents answered "3," and one stated, "You can be really smart, but nobody knows everything, and everybody makes mistakes. If you listen to me, I trust you, and I can forgive you for mistakes. We don't expect you to be perfect." Teachable moments also arose with similarities in responses. Year after year, 100% of the nurses and residents

who answered responded to a question about the nurse-physician relationship the same way: that it was parallel but should be complementary. A discussion would then follow about difference in background, perceptions, and communication strategies that could change this.

These discussions were coupled with a "lessons learned" project as an introduction to performance improvement and patient safety topics. In front of faculty and peers, each resident was asked to formally discuss a medical error or mistake they had been involved in and to review the medical literature to offer a potential system-wide solution to ensure the error did not happen again.

Results

During the 3 years between implementation and data collection, there was only 1 hospital-level action for unprofessional behavior, and that was during the pilot year. Program-level actions for unprofessional behavior were reduced from 4 per year to only 1 during the final year of data collection. The professionalism scores on rotations and end-of-year evaluations did not change significantly, and neither did professionalism scores from recent graduate supervisors. These, however, had variability in evaluators because of turnovers in those positions and, in the case of the resident evaluations, were focused on clinical performance during a 1-month rotation and were not designed to capture the focus of the curriculum. The faculty expressed 100% approval for the program in anonymous, annual program evaluations, and the residents expressed an 80% to 100% overall approval rating, which varied by academic year. The most common criticism of the program was that "professionalism can't be taught" and that "lectures and discussions weren't going to make an unprofessional person change."

Discussion

Our study has several limitations. First, the few subjects and short intervention period reduce the ability to generalize the findings. An added limitation is the lack of objective, outcome measures of professionalism that can be easily transferable from specialty to specialty. Such measures are required for a transitional year training program to assess any such intervention with validity. Our main outcome variable was major lapses in professionalism. This reinforces the observation made by many of our residents during initial development of this curriculum: "I don't know what professionalism is; I only know when it's not there." Defining professionalism for residents remains a challenge⁸ and continues to complicate efforts to teach it.

Conclusion

Our novel transitional residency-specific professionalism curriculum reduced the number of residents undergoing disciplinary action for lapses in professional behavior. Faculty and residents expressed a high level of approval for the program, although the professionalism scores of residents in their evaluations did not change significantly, and military-specific training remains insufficient. The next step entails including didactic teaching of combat trauma and group discussions of the role of the physician in the military-deployment environment.

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