The Little Organization that Could and the Seventh Competency: The 2012 APPD Presidential Address

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FIRST LET ME give you all a resounding thank-you for the past 2 years. The day-to-day interactions with many of you have taught me more than I think I will ever realize. It has been a humbling honor to be part of it all.

When Susan Guralnick, MD, delivered the first APPD presidential address in Chicago in 2010 upon completing her 2-year tenure as APPD's leader, I remember my thoughts and apprehension with great clarity. I thought, too, about Eleanor Roosevelt's sentiments in her newspaper column, "My Day": "People grow through experience if they meet life honestly and courageously. This is how character is built."[1] So today I am in a character-building mode! Susan gave a wonderful presentation, and I was scared to think I must try to do the same. The term *address* really gave me pause as well. Gettysburg *address,* State of the Union *address*—it sounds so formal, so lofty.

Serving as Association of Pediatric Program Directors (APPD) president has been a wonderful adventure for me and has afforded me the true privilege to meet many exceptional people. It is humbling to know and experience such significant intellectual horsepower, depth of passion for education, and nuanced thought that the members of APPD possess. So now, at the end of my tenure as president, I take this opportunity to discuss what I consider to be vitally important concepts about teaching and assessing residents. My objectives will be to 1) discuss professional formation and explore why this complex construct should be of utmost importance to us as educators of young pediatricians, 2) explain how professional formation relates to the APPD and how the APPD is ahead of the curve, and 3) consider the APPD's seventh competency and how we can make this dimension of training more explicit for us and our residents and fellows. It is a nuanced and complex area that is difficult to define, let alone assess in learners.

WHY PROFESSIONAL FORMATION?

The hundredth anniversary of the Flexner report occurred in 2010.[2] That same year, the Carnegie Foundation for the Advancement of Teaching, the organization that sponsored Abraham Flexner's original work, published a book entitled *Educating Physicians: A Call for Reform of Medical School and Residency* that reassessed the current state of medical education.[3] Interestingly, the 4 goals that related to challenges in the framework that Flexner articulated in 1910—standardization, integration, habits of inquiry and improvement, and professional formation—are similar goals 100 years later.[2,3] The issues and context at hand have changed but the themes remain. I will focus on this concept of professional formation.

Let's talk about challenges from the standpoint of professional formation. There are many, and sometimes it seems like they are mounting day by day. Cooke and colleagues,[3] in their call for reform, articulated the following barriers to professional formation: 1) lack of clarity and focus on professional values; 2) failure to assess, acknowledge and advance professional behaviors; 3) inadequate expectations for progressively higher levels of professional commitment; and 4) erosion of professional values because of the pace and commercial nature of health care. We could probably add a few details to some of these categories and drill down a little bit. My top 3 impediments are: 1) time constraints (it is difficult being an intern in 2012—there is no time to reflect, only to simply hurry in, take care of patients, and hurry out); 2) too many things to document and enter in the electronic medical record (EMR; this documentation doesn't teach residents much of anything, other than how to count and type); and 3) rapid change in requirements without clear and significant evidence behind those changes.

What do pediatric residents do while learning on wards? One study from Gabow and colleagues[4] found that only 13% of a second-year pediatric resident's time was spent directly attending to or assessing patients. Another study by Boex and Leahy[5] found that residents devoted approximately 36% of their effort to direct patient care necessary to achieve specialty-specific learning objectives, 15% to the residency program's organized teaching activities, and potentially as much as 35% to delivering patient care of marginal or no educational value. An additional 16% of residents' waking time on duty was spent in other, unspecified, activities. The authors concluded that it is potentially valuable to consider not only the number of hours worked by

residents, but the educational content of that work. Further, Bush and Philibert supported the aforementioned studies when they discussed how graduate medical education funding is outdated and the tasks we have residents do are not always learning oriented.[6] This is echoed by one of my hospitalist colleague's sentiments: "When I go into the fishbowl to talk with the residents, I usually find them with their backs to me placing orders and notes into EPIC or frantically typing discharge summaries. They do not spend enough time getting to know their patients" (G. Toussaint, personal communication).

THE SEEMINGLY UPHILL BATTLE

Overall, we are up against a large foe, real or perceived, that is embodied in changing requirements, duty hour limitations and rules, generational issues, technology problems/advances, and more change. There are a myriad of tugging priorities and agendas with most systems. One of my first president's messages in the APPD newsletter[7] had to do with an analogy between the APPD and the struggles we educators go through and *The Little Engine That Could*.[8] I relayed the story of how my mom used to always read that poem to me when I was a kid, and many times as a program director, I tell myself, "I think I can, I think I can…" The little train had to pull tons of toys over the large mountain to get them to children on the other side. We have our own mountains: How will residents learn and have successful professional formation with so many conflicting pressures and limited time? What to do about duty-hour limitations that almost wipe out time for reflection on their experiences and learning? What to do about electronic medical records, short stays, and high patient turnover, as well as the sentiment, "I am just covering this patient"? We must keep telling ourselves, "I think I can, I think I can…" When thinking about the choices we have, it seems clear that we can get mired in negativity, or we can work to overcome and embrace the challenges to ultimately help our trainees. From what I have observed and been a part of in this organization, I would say that the latter is the general course for the majority of us. One more thing about the little engine that succeeded in getting up over the huge mountain: program directing is much more complex than that simple story. As pointed out in Shel Silverstein's response to *The Little Engine That Could* in his poem "The Little Blue Engine," engines and people may think they can but may end up crashing if they aren't prepared. Silverstein writes, "If the track is tough and the hill is rough, / THINKING you can just ain't enough!"[9]

Thinking we can ain't enough! We must prepare ourselves and our programs and use our collective resourcefulness to identify and elevate what is truly important. From my perspective, one of the key factors in making pediatric medical education alive and well—to make it flourish, in fact, even in these rough times—is to place the concepts of professional formation at the forefront.

THE CONCEPT OF PROFESSIONAL FORMATION

What is professional formation? I will relay a few overlapping definitions. Cooke and colleagues describe it as something that we in medicine are somewhat squeamish about addressing. Perhaps because it is seen as a soft science or as too touchy-feely: We are scientists, for Pete's sake! Why would we want to start dealing with our emotions and those of others? They further define the professional development education to be "inculcating a desire in trainees to be: More compassionate, more humane and more altruistic."[3] Three words that have qualities and characteristics that definitely overlap. Wear defines professional formation as a process that requires habits of thinking, feeling and acting. He thinks physicians should demonstrate "compassionate, communicative and socially responsible physicianhood."[10] Cooke and colleagues conclude, "The physician we envision has, first and foremost, a deep sense of commitment and responsibility to patients, colleagues, institutions, society, and self and an unfailing aspiration to perform better and achieve more."[3] So professional formation is, I think, vitally important.

THE ROLE OF APPD MEMBERS

I must express my great pride in this organization and the astute and insightful members. Before the release of *Educating Physicians: A Call for Reform of Medical School and Residency*[3] at the APPD 2009 annual spring meeting, members were asked what qualities and/or characteristics needed to be made more explicit or weren't articulated in the already existing 6 Accreditation Council for Graduate Medical Education (ACGME) competencies. You guys got it right before the Carnegie Foundation completed their book (Fig. 1). Qualities and attributes surfaced such as dealing with uncertainty; exhibiting humanism and empathy; feeling patient ownership; being trustworthy; and providing self-care. Although the "Pediatrics Milestones Document on Professionalism" encompasses some of the concepts of humanism, the written sentiments from that session were used by the Milestones Working Group to define another competency (C. Carracio, personal communication).

Technically, and according to the ACGME, there are and will forever be only 6 competencies; we thus called this an

Figure 1. *Word cloud based on comments from APPD members in response to the question, "What would you like to see made more explicit or weren't articulated in the existing ACGME competencies?" Overlap with humanism, compassion, and altruism is readily apparent.*

area instead of a competency, and we named it personal and professional development. But with presidential license, I am calling this area the seventh competency. It is interesting how it overlaps with the 3 concepts highlighted in the professional formation: humanism, altruism, and compassion.

HUMANISM, ALTRUISM, AND COMPASSION

To help us all define and better understand the content of the seventh competency, let's look first at some clearer definitions of the terms that embody professional formation. I want to start with the concept of humanism. Cohen[11] describes humanism as a way of being, a deep-seated personal conviction about one's obligations to others that manifests as altruism, duty, integrity, respect for others, and compassion. He goes on to hit the nail on the head by saying, "Humanism provides the passion that animates authentic professionalism." I also like the way Goldberg thinks about this concept: "The accordance of deep respect to humans individually and to humanity collectively, and concern for their general welfare and flourishing."[12] How do we feel about the photograph in Figure 2 by Dorthea Lange, who was commissioned in 1935 by the government during the Roosevelt administration to document the plight of the people affected by the Dust Bowl?[13] One could say Lange was trying to get us all to be more compassionate, more humanistic. The camera is an "instrument that teaches people how to see without a camera."[14]

The other concept in professional formation is altruism. In an article by Burks and Kobius, the concept of altruism is described as "intangible and opaque" despite being the cornerstone of the Hippocratic Oath.[15] It is acknowledged as being the motivation for helping behaviors that are "other-directed" and involves a range of prosocial behaviors, the leading one being empathy. Hojat has defined the construct of empathy as it relates to physicians. He says empathy is a "predominantly cognitive attribute that involves understanding of patient's experiences, concerns, perspectives combined with a capacity to communicate this understanding and an intention to help."[16] He also provided evidence that empathy (based on the Jefferson Scale for Empathy) erodes during medical school.[16] Other studies have demonstrated a similar decrease in empathy and compassion during training.[17] This concept of decline of empathy is disheartening and sad for any physician and medical educator.

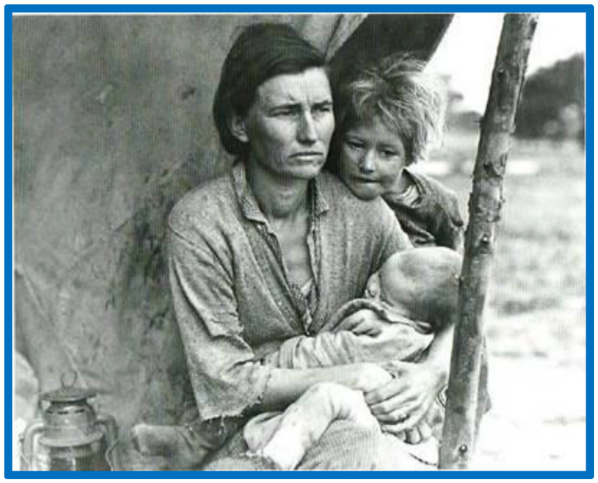

Figure 2. *Migrant mother, Nipoma, California. Photograph by Dorthea Lange. Courtesy of the U.S. Library of Congress.*

The last characteristic in professional formation is compassion. Of course we want our trainees to be compassionate. The definition of compassion bleeds into that of empathy and altruism, as well as into humanistic qualities and descriptors. Compassion is defined as an empathetic consciousness of others' distress together with a deep desire to alleviate it.[18] It manifests in acts of altruism. A quote from the Dalai Lama may say it best: "If you want others to be happy, practice compassion, if you want to be happy, practice compassion."[19] Compassion is a common theme in spirituality as well. A well-known saying in Judaism describes compassion thusly: "Kindness gives to another. Compassion knows no other." In Christianity, the parable of the Good Samaritan embodies compassion and altruism. For another way to consider compassion in the context of medicine, one only need to look to Sir William Osler: "The good physician treats the disease; the great physician treats the patient who has the disease."[20]

LESS TANGIBLE, MORE MEANINGFUL

Now that the virtuous, valued terms humanism, altruism (with empathy), and compassion have been discussed, it becomes clear that teaching and assessing these strong words contained in the construct of professional formation are difficult. However, the seventh competency can assist faculty members in assessing these more ethereal qualities. Consider the basketball player who can shoot well, dribble with control, and play solid defense, yet lacks what coaches would call heart, tenacity or court sense. Without those intangible, less easily defined qualities, a person would not make a very expert basketball player at all. Likewise, this seventh competency more clearly defines some of those less explicit, overlapping, more difficult-to-define qualities that really allow a resident to become the "good doctor." You know what I mean. You have seen them too. We all know residents who are just fine with clinical reasoning skills and medical knowledge, but when stressed, they have immature coping mechanisms and become, for example, short with their colleagues when they think they have too much work or get frustrated with the patient when they can't understand the patient's perspective.

THE SEVENTH COMPETENCY

The Pediatric Milestones Working Group defined 8 topic areas or subcompetencies under the seventh competency (Chart).[21] The underlying concepts from these 8 subcompetencies overlap to a degree, but all are important and have the potential to guide residents and fellows on the path toward professional formation. Note that the concepts of dealing with uncertainty, helping others, taking ownership of patients, and self-motivating play prominent roles in these subcompetencies. Note, too, how there are themes

CHART

PERSONAL AND PROFESSIONAL DEVELOPMENT: THE SEVENTH COMPETENCY

- Develop the ability to use self-awareness of knowledge, skills, and emotional limitations to engage in appropriate help-seeking behaviors.
- Use healthy coping mechanisms to respond to stress.
- Manage conflict between personal and professional responsibilities.
- Practice flexibility and maturity in adjusting to change with capacity to alter behavior.
- Demonstrate trustworthiness that makes colleagues feel secure when one is responsible for the care of patients.
- Provide leadership that enhances team functioning, the learning environment, and/or health care system/environment with the ultimate intent of improving care of patients.
- Demonstrate self-confidence that puts patients, families, and members of the health care team at ease.
- Recognize that ambiguity is part of clinical medicine and respond by utilizing appropriate resources in dealing with uncertainty.

of self-care and balancing the desire to always help others (altruism) with a sentiment of "I need some help." The "use healthy coping mechanisms to respond to stress" subcompetency describes the progression from early to later stages of professional identity formation and how response to stress changes with that developmental process. Early in development, learners may have maladaptive behaviors and may be more prone to burnout.[22] With advancing professional identity formation, residents internalize what it means to be a physician.[23] By internalizing the values and expectations of the profession and making those attributes their own, learner response to stressors tends to become healthier, as that is how more mature, seasoned pediatricians should behave.[21,23] But wait! Burned-out residents? Depressed residents? A 2008 study by Landrigan et al involving 3 large pediatric training programs aimed to determine whether work hours, sleep, and safety changed after the ACGME work-hour limits were implemented.[24] They gathered data regarding burnout and depression on 220 residents. It was noted that the change in work hours coincided with a decrease in burnout, from 75% to 57%. Further, they found nearly 20% of the residents scored positive on a validated screen for depression. There was no significant change in that measure after the change in duty hours. So wait a minute: 57% of residents are burned out, and 20% are depressed. These figures are astonishing to me, and they provide evidence that we need to make this seventh competency more explicit and practiced.

This seventh competency also includes concepts around the development and growth in management of internal conflicts and ethical dilemmas encountered in day-to-day practice. "The process of professional identity formation includes experience and reflection, service, growth in knowledge of self and of the field, and constant attention to the inner life as well as the action of life."[25] These concepts all overlap in the construct of mindful practice, which is cited numerous times in this section of the milestones.[21] In a landmark 1999 *JAMA* article, Epstein describes mindful practice as being attentive, on purpose, to one's own thoughts and feelings during everyday activities to be able to practice with greater clarity, insight, and compassion.[25] Mindful practice implies presence rather than detachment and allows one to see a situation from several angles at the same time.

The ability to be flexible is another key concept that allows a mature professional to adjust to change and potentially alter behavior. Flexibility is defined in the psychology literature to include 3 distinct domains: the tendency to perceive difficult situations as controllable, the ability to perceive multiple alternative explanations for life occurrences and human behavior, and the ability to generate multiple alternative solutions to difficult situations. Emotional intelligence is a characteristic deeply involved in this milestone.[21] Emotional intelligence is described in many ways, but it generally consists of: 1) having the ability to perceive emotions in oneself and others, 2) facilitating thought, or the ability to generate, use, and feel emotion to communicate feelings or employ them in other cognitive processes, 3) understanding emotions, or the ability to understand information and how emotions combine and then to progress through relationship transitions and appreciate such emotional meanings, and 4) managing emotions, or the ability to be open to feelings and to modulate them in oneself and others so as to promote personal understanding and growth.[26,27]

The last concept from the seventh competency is trustworthiness. Trustworthiness is defined by Kennedy and colleagues as a combination of factors that consist of 4 dimensions: ability or level of knowledge skills and attitudes, discernment, conscientiousness, and truthfulness.[28,29] It is not being used in the general sense of being trusted. Rather, it is used to describe information that may provide supervising clinicians help in decision making regarding when they may be able to count on an individual to carry out a given task, make reasonable decisions, and take care of patients in a specified context with minimal (or no) supervision.[21,28] I encourage all educators to review this specific pediatric milestone and the literature on trustworthiness. As I have (I hope) demonstrated, this seventh competency covers much ground in regards to defining the terms the APPD wanted to make more explicit for residents.

MOVING UP AND FORWARD

These important concepts of the less tangible, important seventh competency have recently received some significant emphasis by some of my esteemed colleagues. Steve Ludwig's Joseph St Geme Award address, "Striving for Polygamy," discussed the 3 marriages between family, self, and work, and it formally highlighted the concepts of self-care and balance.[30] Further, Janet Serwint's presidential address to the Academic Pediatric Association (APA) in 2011 relayed her hope that we consider the great

importance of humanism in our day-to-day lives and work, to recognize and appreciate our own humanism and to utilize specific strategies to enhance self-care.[31]

So what did the Carnegie report recommend doing to empower professional formation? They suggested we do the following: 1) promote formal ethics instruction, storytelling, and symbols (honor codes, white coat ceremony); 2) address the underlying messages in the hidden curriculum and strive to align the espoused and enacted values of the clinical environment; 3) offer feedback, opportunities for reflection, and assessment of professionalism in the context of longitudinal mentoring and advising; and 4) promote relationships with faculty who simultaneously support learners and hold them to high standards.[3] The APPD is moving up that proverbial mountain with the development and implementation of the seventh competency.

I have discussed the challenges we face. I have discussed the emphasis that I think needs to be placed on the important stuff to get us over the mountain. I have outlined some highlights from the APPD-driven seventh competency. What must we do specifically is: 1) raise the bar of professional formation, 2) practice humanism, empathy, and compassion, 3) celebrate and use the seventh competency, 4) embrace and enjoy what we do each day, and 5) take good care of ourselves and others.

It is only fitting to end with a rhyme, which many of you may be expecting from me:

> The little engine was neither yellow nor blue,
> It is us, our programs, me and you!
> Try as we may, try as we might
> We worry, we stress, we stay up at night.
> But take heart, feel, know what is real,
> Teaching professional formation and being in our jobs is a steal!
> Meaningful qualities to our learners; let us bestow,
> So toward the "Good Doctor," residents will continue to grow.
> Guided by compassion, altruism, and empathy,
> This seventh competency will guide us. Go APPD!
> —In the style of *The Little Engine That Could* by Watty Piper (1930)

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