Faculty Development as an Instrument of Change: A Case Study on Teaching Professionalism

Yvonne Steinert, PhD, Richard L. Cruess, MD, Sylvia R. Cruess, MD, J. Donald Boudreau, MD, and Abraham Fuks, MD

Abstract

Faculty development includes those activities that are designed to renew or assist faculty in their different roles. As such, it encompasses a wide variety of interventions to help individual faculty members improve their skills. However, it can also be used as a tool to engage faculty in the process of institutional change. The Faculty of Medicine at McGill University determined that such a change was necessary to effectively teach and evaluate professionalism at the undergraduate level, and a faculty development program on professionalism helped to bring about the desired curricular change. The authors describe that program to illustrate how faculty development can serve as a useful instrument in the process of change.

The ongoing program, established in 1997, consists of medical education rounds and "think tanks" to promote faculty consensus and buy-in, and diverse faculty-wide and departmental workshops to convey core content, examine teaching and evaluation strategies, and promote reflection and self-awareness. To analyze the approach used and the results achieved, the authors applied a well-known model by J.P. Kotter for implementing change that consists of the following phases: establishing a sense of urgency, forming a powerful guiding coalition, creating a vision, communicating the vision, empowering others to act on the vision, generating short-term wins, consolidating gains and producing more change, and anchoring new approaches in the culture. The authors hope that their school's experience will be useful to others who seek institutional change via faculty development.

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> The challenge for professional education is how to teach the complex ensemble of analytic thinking, skillful practice, and wise judgment upon which each profession rests.
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> —William M. Sullivan, *Work and Integrity: The Crisis and Promise of Professionalism in America*, 2005

Effecting change in any large organization is difficult, and faculties of medicine (i.e., medical schools) are no exception. They are complex systems, with multiple stakeholders who care deeply about their institutions. Many stakeholders have a vested interest in the activities of their organizations, and all can be counted on to have opinions about future directions. Several observers have commented on the difficulty of implementing change within the medical profession and its institutions, which have been described as being inherently conservative and devoted to the status quo.[1–4] To assist them, some faculties of medicine have used outside consultants to bring formalized management techniques into the change process.[5,6]

We at the Faculty of Medicine at McGill University have found it useful to apply an eight-stage model for implementing change,[7,8] used in the field of management, to analyze certain steps that we have taken to effect change at our school, and we wrote this essay to suggest that faculty development can serve as a useful instrument in the process of change.

Faculty development can help to build consensus, generate support and enthusiasm, and implement a change initiative; it can also help to change the culture within the institution by altering the formal, informal, and hidden curricula.[9,10] To illustrate this phenomenon, we will describe the role of a faculty development program—designed to enhance the teaching and evaluation of professionalism—in helping to promote change in the undergraduate medical curriculum of the Faculty of Medicine at McGill University. We hope that our experience can serve as a useful example for others.

Faculty development has been defined as that broad range of activities that institutions use to *renew* or *assist* faculty in their roles.[11] That is, faculty development is a planned program, or set of programs, designed to prepare institutions and faculty members for their various roles.[12] For some years, it has been recognized that comprehensive faculty development programs cannot focus solely on individual improvement; they must also address the increasingly complex institutions in which teaching and learning occur.[13,14]

The Importance of Professionalism

The past few decades have witnessed the development of a profound sense of unease amongst physicians and patients. Physicians feel that they are being "held to account for sins of both commission and omission,"[15] for their attitudes towards patients and for their emphasis on medical technology. At the same time, patients express a strong desire for care that is based on modern scientific medicine combined with the compassion of the physician of yesteryear. They wish respect for their own autonomy, accountability and transparency from their physicians, and, above all, the services of a competent healer.[15] These latter qualities have come to be recognized

Please see the end of this article for information about the authors.

Correspondence should be addressed to Dr. Steinert, Associate Dean and Director, Centre for Medical Education, Faculty of Medicine, Lady Meredith House, McGill University, 1110 Pine Ave. W., Montreal, Quebec, H3A 1A3 Canada; telephone: (514) 398-2698; fax: (514) 398-6649; e-mail: (yvonne.steinert@mcgill.ca).

as those traditionally associated with the skilled professional, and there is general agreement that many of medicine's failures to meet legitimate public expectations lie in the realm of professionalism.[2–4,16,17]

The medical profession has responded.[18] A number of authors have analyzed professionalism, defining the concept and its attributes, outlining the obligations necessary to sustain it, and describing its relationship to medicine's social contract with society.[19–22] There has also been a groundswell of activity aimed at developing better means of teaching and evaluating professionalism among students, residents, and practitioners.[19,23–31]

In addressing these issues, McGill's Faculty of Medicine realized early on that the teaching of professionalism could not depend solely on the establishment of a single course or selected curricular activities with a narrow focus or limited objective. In our opinion, the challenge to contemporary medicine and its value systems was so serious that it required significant curricular change.

Teaching and Learning Professionalism

Professionalism was traditionally transmitted from one generation to the next by respected role models.[32–34] It is believed that this method was successful, in part, because the medical profession was fairly homogeneous and, despite some generational differences, shared values were the norm. In today's wonderfully complex and diverse society, one can no longer assume shared values, and the challenges to the traditional values of the medical profession posed by modern health care systems are new. It has therefore been concluded that role modeling, while remaining a powerful and essential tool, is no longer sufficient.[24,34] Professionalism must be taught explicitly. Furthermore, there has been increased recognition that the environment within the teaching institution has a significant effect on the teaching of professionalism and must be addressed.[9,10,35,36]

The literature indicates several approaches that must be considered if professionalism is to be taught effectively and internalized by students. There are those who have emphasized that professionalism needs to be taught explicitly, using either operational definitions or outlining the concept as a list of traits or characteristics.[19,20,22] Others have stated that the teaching of professionalism should be approached as a moral endeavor, emphasizing altruism and service.[29,30] We, and others,[24,35,36] believe strongly that both approaches are essential. The cognitive base must be defined and communicated so that physicians understand the nature of professionalism, its relation to medicine's social contract, and the obligations that must be met if professionalism is to survive. In addition, opportunities for experiential learning must be provided on a regular basis to promote self-reflection[37] and "mindfulness,"[23] so that professionalism will not remain a theoretical or marginal concept. Professional identity arises from a combination of experience and informed reflection on experience.[38] Therefore, a major objective of medical education should be to provide multiple, stage-appropriate opportunities for gaining experience in, and reflecting on, the concepts and principles of professionalism.[25,29,30]

Professions use collegiality as a means of obtaining agreement on common goals and encouraging compliance with them.[39] The peer pressure of respected role models remains an enormously powerful tool. Conversely, the destructive effects of role models who fail to meet acceptable standards can be equally strong.[29,30,40] To be effective, it seems axiomatic that role models must understand and be able to articulate the roles and values that they are expected to demonstrate. To us, this was the most cogent argument for creating and implementing a faculty development program designed to promote the teaching and evaluation of professionalism. In addition, we hoped that it would positively influence both the informal and hidden curricula[9,10] by promoting self-reflection in faculty members and sending a strong message that professionalism is important.

The Context for Change

The Faculty of Medicine at McGill University offers a four-year, integrated, systems-based undergraduate program. In 1996, the first formal session on professionalism was presented to second-year students. It immediately became apparent that the subject was too important, and too complex, to be covered in a single lecture; however, there was little faculty awareness of professionalism, and few faculty members were knowledgeable enough to participate in an expanded teaching program. It was therefore decided that a comprehensive and systematic faculty development initiative was needed to promote faculty "buy-in," to develop consensus on educational goals and content, and to train faculty members to teach and evaluate professionalism more effectively. A working group was also established by the dean of medicine to examine how we could more systematically teach the role of *healer*, a concept that is included in the word *professional* by most other faculties of medicine. This working group relied on local expertise,[41,42] a visiting professor who had written extensively on healing,[42,43] and the participation of the associate deans responsible for faculty development and undergraduate medical education, so that faculty development could support the teaching and evaluation of both endeavors.

Faculty Development as an Example of "Leading Change"

The faculty development program designed to enhance the teaching and evaluation of professionalism at McGill University has been described previously.[44] For the purpose of this case study, we have decided to analyze what we have done since 1997 and how our program served as a catalyst in the process of undergraduate curricular change, using Kotter's model for *leading change*.[7,8] Although we did not use the Kotter model in planning this faculty development program, we soon realized that we had followed the steps recommended by Kotter for transforming organizations.[8] We believe that this approach is particularly useful in helping to understand the role of faculty development in the process of change, and that it, and McGill's experience, could be instructive to others as they consider curricular change and renewal.

Below, we explain Kotter's model and the eight steps he recommends for transforming organizations.

Establish a sense of urgency

Kotter states that establishing a sense of urgency is critical to gaining needed cooperation, because transformation efforts fail to achieve their objectives when complacency levels are high.[7,8] Moreover, establishing urgency demands that the sources of complacency be removed or their impact minimized; the latter can be achieved by setting higher standards or changing the internal systems of measurement. In our own setting, and indeed in most medical schools, this sense of urgency was provided by the widespread belief that medicine's professionalism and professional status were being threatened by contemporary health care systems, whose values are difficult to reconcile with those traditionally associated with medicine.[1,4,16,17] Without question, the actions of licensing and accrediting bodies reinforced the sense of urgency felt by the faculty and provided a potent stimulus for change. The recognition of professionalism as an essential competency by the Royal College of Physicians and Surgeons of Canada,[45] the American Board of Medical Specialties,[46] the Accreditation Council for Graduate Medical Education,[47] as well as the support of the Association of American Medical Colleges[48] and the American Board of Internal Medicine,[49] created a need for timely action on the part of medicine's educational institutions. However, the knowledge, attitudes, and skills to do this effectively were not readily apparent. In our own context, this *sense of urgency* was communicated to our faculty members through the leadership of the faculty of medicine as well as through a series of educational activities sponsored by the faculty development office, starting with medical education rounds in 1997. Table 1 outlines our faculty development initiatives within the context of Kotter's model for *leading change*.

Form a powerful guiding coalition

Kotter eloquently states that "because major change is so difficult to accomplish, a powerful force is required to sustain the process."[8 (p51)] He also highlights the key characteristics of a team that can direct a change initiative. These characteristics include position, power, expertise, credibility, and leadership. In our own setting, in June 1999, the dean initiated the process of creating a *powerful guiding coalition* by inviting 25 educational leaders, consisting of the associate deans responsible for undergraduate and postgraduate medical education, members of the faculty development team, key departmental chairs, program directors at the undergraduate and postgraduate levels, and local content experts, to a half-day "think tank." The goal of this session was to highlight the importance of professionalism, to begin to develop consensus among diverse educational leaders, and to discuss ways of reaching out to faculty members across

Table 1

Using Kotter's Eight-Step Model to Analyze the Role of Faculty Development in Curricular Change in the Faculty of Medicine at McGill University*

Steps in "leading change"[7,8]	Faculty development initiatives	Impact on the faculty and the undergraduate curriculum
Establish a sense of urgency	Medical education rounds on professionalism	Highlighted to the institution the increasing importance of professionalism in medical education
Form a powerful guiding coalition	"Think tank" on teaching professionalism	Established an informal "interest group" on professionalism and contributed to enhanced visibility within the faculty
Create a vision	Invitational workshop on teaching professionalism	Resulted in the creation of a cohort of small-group teachers knowledgeable in this emerging domain; led to a set of general recommendations regarding the teaching of professionalism
Communicate the vision	Faculty-wide workshop on teaching professionalism	Contributed to the dissemination of the vision throughout the academic community (e.g., via hospital-based grand rounds; small-group sessions on professionalism in the undergraduate curriculum; peer-reviewed articles)
Empower others to act on the vision	Departmental workshops on teaching professionalism	Resulted in a detailed report submitted to the associate dean that led to the establishment of working groups on professionalism, healing, and evaluation
Generate short-term wins	"Think tank" on evaluating professionalism; faculty-wide workshop on evaluating the physician as healer and professional; faculty-wide workshop on teaching communication skills	Resulted in the development and piloting of a specific tool to evaluate professionalism (i.e., the P-MEX); led to the adoption of a particular model to teach communication skills; helped to catalyze the creation of a task force mandated to renew the curriculum according to the concept of physicianship
Consolidate gains and produce more change	Faculty retreat on curricular renewal	In partnership with the curriculum committee, this retreat led to a formal endorsement of the physicianship curriculum
Anchor new approaches in the culture	Faculty development workshops for the Osler Fellows (who are mentors for medical students)	Enables the ongoing preparation and "renewal" of faculty members involved in the implementation and delivery of the physicianship curriculum

* The authors found this model by J.P. Kotter helpful in analyzing the steps that their institution, the Faculty of Medicine at McGill University, took to effect changes in teaching and evaluating professionalism via faculty development.

the basic science and clinical teaching sites. To achieve its objectives, the think tank started with a brief overview of the core content of professionalism and a review of how professionalism was being taught at all levels of the undergraduate curriculum. After a lively debate and exchange of ideas, consensus on the importance and content of teaching professionalism was reached. A plan for a faculty development workshop was also developed.

Create a vision

"Vision refers to a picture of the future with some implicit or explicit commentary on why people should strive to create that future."[8 (p68)] Moreover, vision clarifies the direction of the change and helps to both motivate and align key players. At McGill, the think tank described above helped to create the vision for teaching and evaluating professionalism. More importantly, however, an invitational half-day workshop, which grew out of this first session and focused on teaching professionalism, led to the creation of a vision that we could then articulate faculty-wide. In December 1999, the dean invited all department chairs and undergraduate and postgraduate program directors to a half-day workshop designed to examine the working definition of professionalism and its attributes and to determine the strengths and weaknesses of diverse teaching methods. More specifically, the workshop was organized into three parts: the *core content* of professionalism, the participants' personal views and beliefs, and strategies for teaching.[44] By the end of this session, we had developed a broad agreement regarding the importance of professionalism and its core content, discussed ways of implementing the teaching of professionalism in specific departments and sites, and developed a plan for a faculty-wide workshop. We had also prepared a cohort of small-group facilitators for future workshops and teaching sessions and devised a series of recommendations regarding the teaching of professionalism that were presented to the undergraduate and postgraduate curriculum committees. The two key messages of this workshop were (1) the need to make the teaching of professionalism *explicit*, and (2) the importance of *role modeling*. List 1 presents definitions of three terms that are important to an understanding of medical professionalism, and List 2 defines core attributes of the healer and the professional, and the attributes that they share. The definitions in both lists were refined by participants during this and subsequent faculty development activities.

List 1

Definitions of Three Terms Important to an Understanding of Medical Professionalism*

Profession: An occupation whose core element is work based on the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded on it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served, to the profession, and to society.[60]

Heal: To make whole or sound in bodily condition; to restore to health or soundness; to free from disease or ailment; to cure (of a disease or wound).[61]

Physician: One who practices the healing art, including medicine and surgery; one legally qualified to practice the healing art.[61]

*These definitions, based on definitions in the literature, were refined during half-day faculty development activities in the Faculty of Medicine at McGill University in December 1999, December 2000, and May 2002.

List 2

Core Attributes of the Healer and of the Professional and the Attributes They Share*

Attributes of the Healer

Caring and compassion: a sympathetic consciousness of another's distress together with a desire to alleviate it.
Insight: self-awareness; the ability to recognize and understand one's actions, motivations and emotions.
Openness: the willingness to hear, accept, and deal with the views of others without reserve or pretense.
Respect for the healing function: the ability to recognize, elicit, and foster the power to heal inherent in each patient.
Respect for patient's dignity and autonomy: the commitment to respect and ensure subjective well-being and sense of worth in the patient and recognize the patient's personal freedom of choice and right to participate fully in his or her care.
Presence: to be fully present for a patient without distraction and to fully support and accompany the patient throughout care.

Attributes of the Healer and the Professional

Competence: to master and keep current the knowledge and skills relevant to medical practice.
Commitment: to be obligated or emotionally impelled to act in the best interest of the patient; a pledge given by way of the Hippocratic Oath or its modern equivalent.
Confidentiality: to not divulge patient information without just cause.
Autonomy: the physician's freedom to make independent decisions in the best interest of the patients and for the good of society.
Altruism: the unselfish regard for, or devotion to, the welfare of others; for example, placing the needs of the patient before one's self-interest.
Trustworthiness: worthy of trust, reliable.
Integrity and honesty: firm adherence to a code of moral values; incorruptibility.
Morality and ethics: to act for the public good; for example, conformity to the ideals of right human conduct in dealings with patients, colleagues, and society.

Attributes of the Professional

Self-regulation: the privilege of setting standards; being accountable for one's actions and conduct in medical practice and for the conduct of one's colleagues.
Responsibility to society: the obligation to use one's expertise for, and to be accountable to, society for those actions, both personal and of the profession, which relate to the public good.
Responsibility to the profession: the commitment to maintain the integrity of the moral and collegial nature of the profession and to be accountable for one's conduct to the profession.
Teamwork: the ability to recognize and respect the expertise of others and work with them in the patient's best interest.

*These definitions were refined during half-day faculty development activities in the Faculty of Medicine at McGill University in December 1999, December 2000, and May 2002.

Communicate the vision

Kotter states that "the real power of a vision is unleashed only when most of those involved in an activity have a common understanding of its goals and direction."[8 (p85)] The vision for teaching and evaluating professionalism at McGill was communicated through the support given by the dean and the associate deans. It was also promulgated by another faculty-wide workshop on teaching professionalism that accommodated 65 health care professionals representing the basic sciences and all major medical specialties. This workshop, which was held in December 2000, was designed to highlight the importance of teaching professionalism and to improve such teaching by transmitting core content, discussing effective teaching strategies, and developing an action plan for each department. This workshop resulted in increased buy-in among the educational leaders who participated, and it led to the development of new content experts and an array of educational resources that could be used for teaching purposes. It also led to a number of other activities designed to communicate the vision for change, including educational sessions for residents, hospital grand rounds, departmental workshops, and high-profile activities outside McGill such as peer-reviewed publications and presentations at national and international meetings.

Empower others to act on the vision

Kotter specifically identifies the provision of training as one of the five essential ingredients to empower people to effect change.[7] In our context, faculty development has been one of the major vehicles for empowering others to lead the change initiative. Knowledge of the importance of the issues became widely recognized as a result of the think tanks and workshops, during which workable solutions appropriate to McGill's culture and environment were developed. Methods used in the workshops, which included case vignettes, organizing frameworks for matching content to methods, and opportunities for experiential learning and reflection, empowered our educational leaders and colleagues. In many ways, the faculty development program allowed our faculty members to agree on the cognitive base of professionalism, the attributes and characteristics of the professional, and the behaviors to be encouraged among students, residents and faculty. It also provided us an opportunity to explore further how *healing*, a concept that is essential to the medical mandate, could be integrated into our teaching program.[19] Faculty members came to realize that the cognitive base of professionalism and healing must be communicated to students, and that diverse teaching and evaluation strategies should be used. This reflection and discussion also led to a vision for renewal of the undergraduate medical curriculum based on the dual roles of the physician: professional and healer (see List 2).

Generate short-term wins

Kotter highlights the importance of short-term wins in promoting change, providing reinforcement for the efforts taken, helping to fine-tune the vision and strategies implemented, and building momentum.[7,8] In our context, we experienced the following short-term gains:

- The design and implementation of small-group teaching sessions on professionalism in the first, second, and fourth years of the undergraduate curriculum
- The development of a faculty-wide residency teaching program on professionalism
- Departmental grand rounds in local hospitals, reaching out to the departments of medicine, pediatrics, surgery, obstetrics and gynecology, orthopedic surgery, cardiac surgery, thoracic surgery, anesthesia, and emergency medicine
- The delivery of site-specific workshops in diverse hospital departments (e.g., anesthesia, medicine, obstetrics/gynecology, ophthalmology, surgery)

Although all of these gains did not directly target the undergraduate curriculum, they did have an impact, as many of our teachers teach both students and residents, and many of our residents teach our students.

Our early efforts to promote the teaching of professionalism also led to the need to focus on the evaluation of professionalism. Although aspects of professionalism were being assessed routinely on in-training evaluations, improvement was needed. Thus, several years after this change initiative started, we held another think tank, this time on evaluating professionalism. It was clear to us that for teaching to be successful, professionalism would need to be evaluated in a more systematic way. Thus, we invited 20 educational leaders and content experts to examine methods of evaluating professionalism and to develop the content and methodology of a workshop in this area. At the time, we realized that the attributes of a physician as professional and healer had to be integrated for evaluations to be comprehensive; we therefore added a definition of healing, including the attributes of the physician as healer, which had been developed and agreed on by a work group on healing (as outlined in List 1 and List 2). The outcome was a detailed plan for a faculty-wide workshop, called *Evaluating the Physician as Healer and Professional*, in May 2002.

This workshop was attended by 95 faculty members and focused on developing methods for evaluating the physician as healer and professional at the undergraduate and postgraduate levels by defining specific, observable behaviors for each attribute, examining different approaches to evaluating professionalism,[26,27,50] and assessing the benefits and limitations of different evaluation methods (e.g., global rating scales; portfolios; critical incidents). Organizing frameworks were also used to guide the identification of desirable and undesirable behaviors, the "matching" of methods to behaviors, and the feasibility of different assessment approaches. This workshop led to a consensus on the need to improve the evaluation of professionalism at McGill, and it resulted in a series of recommendations that were presented to the Faculty of Medicine. According to Kotter, short-term wins usually have three characteristics: they are visible, they are unambiguous, and they are clearly related to the change initiative. In our own setting, these characteristics were achieved. The short-term wins also helped to demonstrate the value of our early efforts, gave us the opportunity to celebrate early successes, and brought additional players into the fold.

Consolidate gains and produce more change

Kotter states that the declaration of "early victory" and resistance to change can undermine early success.[8] It is therefore critical to consolidate gains and, often, to

produce *more change*. New projects, themes and change agents can reinvigorate the process. In our setting, the consolidation of gains occurred in a number of ways. After the first faculty development workshop on teaching professionalism, a debriefing session took place that involved the workshop planners, the associate deans, and the small-group facilitators. In addition to discussing the workshop process, a consensus emerged that further faculty action was required to ensure that students understood professionalism and behaved according to its precepts. Thus, a report to this effect was sent to the dean and the associate dean responsible for undergraduate education, emphasizing the need to teach the principle that the physician fulfills two roles: that of healer and professional. This report, which used the word *physicianship*—a term already used by Cassell[51] and Papadakis and colleagues[52] to refer to these dual roles—recommended that a distinct program on physicianship be established, based on separate, but complementary, approaches to the healer and the professional. It also included numerous detailed suggestions for teaching strategies across all four years of the curriculum.

This report was reviewed by the curriculum committee, which is chaired by the associate dean responsible for undergraduate education. This committee chose to establish three working groups consisting largely (but not entirely) of individuals who had been involved in the faculty development program on professionalism. The mandate of the first was to recommend a curriculum on teaching professionalism. The second working group focused on the teaching of the healer role. The third was established to look at new ways of evaluating the physician as healer and professional, as it was recognized that a system of evaluating students had to be linked to the teaching of physicianship.

The recommendations of these working groups, some of which evolved directly from the faculty development workshops, and all of which enjoyed the strong support of the dean, formed the basis of subsequent faculty development activities aimed at supporting and informing curricular change. Briefly, these recommendations suggested that we should:

- establish a longitudinal four-year program on physicianship that would include specific activities devoted to teaching the roles of the healer and the professional;
- create new learning experiences and regroup existing successful activities under the umbrella of physicianship; and
- revise McGill's evaluation system.[53]

These recommendations also stressed that the cognitive base of physicianship be taught explicitly and that opportunities for reflection on physicianship be provided throughout the curriculum. The importance of communication skills to the dual roles of healer and professional was also recognized, and a faculty-wide workshop on teaching communication skills was organized in February 2004. The goal of this workshop, which welcomed 80 faculty members, was to introduce and explore different models of teaching communication skills, and after the workshop, a newly established committee recommended that we implement the Calgary–Cambridge model,[54,55] a successful model of teaching communication skills, at McGill. Finally, the recommendations of the three working groups, as well as the committee on teaching communication skills, were discussed by a special task force mandated to make specific, detailed recommendations for curricular renewal. The task force report[56] was approved by the curriculum committee, the dean, and the faculty executive; it was also endorsed by the entire faculty leadership, including departmental chairs, at a retreat specifically devoted to curricular change.

Anchor new approaches in the culture

According to Kotter,[7] the final step in transforming an organization is to institutionalize the new approaches in the culture of the institution. This refers to articulating the connections between new behaviors and cultural norms and developing the means to ensure leadership development and succession. New approaches are being anchored in the culture of the Faculty of Medicine at McGill University by implementing a major revision to the undergraduate curriculum based, in part, on the different suggestions made during the faculty development workshops. Moreover, endorsement of curricular renewal at the Faculty of Medicine retreat led to the following recommendations, all of which have now been implemented.

- The overall organization of the scientific and clinical aspects of the systems-based curriculum should remain unchanged.
- A longitudinal four-year course, addressing the role of the healer and the professional, should be established under the umbrella of physicianship.
- There should be separate activities devoted to teaching the roles of the physician as healer and professional.
- There should be class-wide "flagship activities" devoted to physicianship on a regular basis throughout the four years of instruction; these would include the body donor service and the white coat ceremony.
- Existing and successful learning experiences should be regrouped under a series of courses on physicianship; this would include the teaching of ethics, spirituality, and palliative care medicine.
- Emphasis should be placed on providing a cognitive basis for the role of the healer and the professional and creating regular, stage-appropriate opportunities for experiential learning and reflection on the two roles throughout the four years of undergraduate education.
- A mentorship program, using respected role models, should be established. The mentors, called *Osler Fellows*, would work with six medical students, who would remain with them for four years. A separate series of faculty development workshops, specifically designed for the Osler Fellows, would help to build a sense of community, ensure understanding of the objectives and methods of the proposed program, and foster the acquisition of new skills such as narrative medicine[57] and reflective practice.[38]
- The mentors should supervise the creation of a *physicianship portfolio* for each student. The portfolio,[58] which would include material relevant to the roles of the healer and the professional, should be paper based, designed to promote self-reflection, and not used for summative evaluation.
- Each student should be required to pass the physicianship course before proceeding to the next year.
- It would be important to establish a revised system of evaluating

professional behaviors. A pilot study of a new method, the Professionalism Mini-Evaluation Exercise (P-MEX),[59] a modification of the mini-CEX[60] that grew directly out of the workshop called *Evaluating the Physician as Healer and Professional*, has been completed. A revised global assessment form, using the behaviors identified in the workshop, has been designed and is now being used in the undergraduate program. We are also considering the implementation of a system for student evaluation of faculty professionalism.

- The associate dean responsible for undergraduate medical education should complete his term and become the director of the office of curriculum development. Several faculty members would be chosen to serve as directors of different aspects of the new physicianship program.
- A review of many of the elements of the clinical method (e.g., the template for the written case report; the physical examination) should be undertaken by the Faculty of Medicine.
- A revised and expanded course on communication skills should be instituted, based on the Calgary–Cambridge guides to the medical interview.[54,55]
- External consultants, including Drs. Eric Cassell and Rita Charon, should assist in the implementation of the new curriculum and the evaluation of its impact.

As this article is being published, the third year of the new curriculum is under way, with the third group of Osler Fellows in place.

Discussion

The change to McGill's curriculum occurred because of the realization that there was a need for change, ongoing support from the leadership of the faculty, the presence of local experts and champions for professionalism and healing, and the implementation of a strong faculty development program. The vision for curricular change at McGill grew slowly from the moment when it was appreciated that professionalism required more than one lecture or designated teaching activity. Moreover, it was recognized early that both the informal and hidden curricula required attention and that the faculty had to be fully engaged for meaningful change to occur.

As we have outlined in this article, faculty development has been implicated at every step, from the initial workshops, which communicated the nature of professionalism to the faculty, to the sessions exploring methods of teaching and evaluation, the roles of the healer and the professional, and the concept of physicianship. More recently, faculty development has been involved in training the Osler Fellows, focusing on their roles as mentors and small-group facilitators, and introducing them to the concept of portfolios, reflective practice, and narrative medicine. At the same time, we are quite aware that we still have many faculty members who are, as yet, uninformed about professionalism and how to teach it, and we need to develop new activities to reach them as well. However, the momentum that has been built during the past decade is likely to continue, particularly as the overall vision enjoys broad faculty support.*

Clearly, a number of factors, including strong support from the dean and other educational leaders, have played a critical role in this change initiative. It must also be stressed that the curriculum has evolved during the past 10 years, and many of the flagship activities had been in place for several years and were functioning well. It is also too early to assess the results of our curriculum, which is still a "work in progress." Although the educational blueprint is in place, additional activities need to be planned and implemented, and, as is true with any curriculum, there will undoubtedly be unforeseen events requiring adjustments. In the short term, we need to introduce activities into each major academic unit of the curriculum to allow for experiential learning of the roles of healer and professional. Also, the importance of residents in the learning experience of medical students has led us to recognize that further education of residents as role models is required. The identification of behaviors indicative of professional values and the development of the P-MEX has allowed us to begin to address the issue of evaluation, but we, along with most of the profession, must still do better, and we must begin to evaluate the professionalism of our faculty members.

However, several things can be said with confidence. More than 300 faculty members have voluntarily spent at least a half-day at faculty development workshops focusing on the teaching and evaluation of professionalism; we now have a cadre of clinical teachers, small-group leaders, and mentors, all of whom have enabled us to expand the teaching of professionalism in an incremental fashion throughout the faculty; and our faculty development program has had an impact on both the informal and the hidden curriculum, as students, residents, and faculty are aware of the nature of professionalism and the importance of professional behavior. Faculty development has clearly been a powerful instrument of change in our setting, and we hope that other programs can benefit from some of our lessons learned.

*Although it is beyond the scope of this article to describe the overall structure and funding of the faculty development program at McGill, it should be noted that funds for this faculty development initiative came out of the program's base budget; no special funds were sought.

Dr. Steinert is professor, Family Medicine, associate dean, Faculty Development, and director, Centre for Medical Education, Faculty of Medicine, McGill University, Montreal, Quebec, Canada.

Dr. Richard Cruess is professor, Surgery, and core faculty, Centre for Medical Education, Faculty of Medicine, McGill University, Montreal, Quebec, Canada.

Dr. Sylvia Cruess is professor, Medicine, and core faculty, Centre for Medical Education, Faculty of Medicine, McGill University, Montreal, Quebec, Canada.

Dr. Boudreau is associate professor, Medicine, director, Office of Curriculum Development, and core faculty, Centre for Medical Education, Faculty of Medicine, McGill University, Montreal, Quebec, Canada.

Dr. Fuks is professor, Medicine, and former dean, Medicine, Faculty of Medicine, McGill University, Montreal, Quebec, Canada.

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