

# ULRR

## **'Be' Report - Stakeholder Feedback on Proposed 'Be' Template & Content. Dissemination and Feedback on a Proposed Template and Content for the Intern Curriculum Framework.**

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June 2022

# STAKEHOLDER FEEDBACK ON PROPOSED 'BE' TEMPLATE AND CONTENT

DISSEMINATION AND FEEDBACK ON A PROPOSED TEMPLATE AND  
CONTENT FOR THE 'BE' COMPONENT OF THE INTERN CURRICULUM  
FRAMEWORK

NATASHA K. SLATTERY



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## Glossary of Abbreviations

**ACGME:** American Accreditation Council for Graduate Medical Education

**CanMEDS:** Canadian Medical Education Directives for Specialists

**CBME:** Competency-based medical education

**CPD:** Continuing Professional Development

**EPA:** Entrustable Professional Activity

**ICGP:** Irish College of General Practitioners

**INE:** Intern Network Executive

**L-PAT:** Longitudinal Professional Assessment Tool

**MCI:** Medical Council of Ireland

**MIB:** Medical Intern Board

**MSF:** Multi-Source Feedback

**NDTP:** National Doctors Training and Planning

**RACP:** Royal Australasian College of Physicians

**RCPI:** Royal College of Physicians of Ireland

**RCPSC:** Royal College of Physicians and Surgeons of Canada

**RCSI:** Royal College of Surgeons of Ireland

**WBA:** Workplace-based assessment

## Definitions

### **Competency-Based Medical Education (CBME)**

CBME defines specific behaviour-linked competencies that must be met during training for a trainee to be deemed ready for unsupervised practice.

### **Competencies**

Competencies are observable abilities of a health professional related to a specific activity that integrate knowledge, skills, values, and attitudes (Frank et al., 2010).

### **Domains**

A specific section of a curriculum that specifies a category of information and skill. Domains are broad in nature. Domains are subdivided into themes.

### **Entrustable professional activities (EPAs)**

EPAs are a bundle of tasks that perform an essential healthcare service. The performance of an EPA allows a trainee to demonstrate multiple competencies within a specific workplace-based task (for e.g., the Intern EPA '*Admit a patient*' involves many competencies including: *establish rapport with patient, communicate with senior colleagues, follow prescribing protocols*). An EPA is observed by a trainer with the purpose of establishing a level of entrustment.

### **Entrustment decisions**

A trainee must demonstrate satisfactory performance of all competencies within a particular EPA to be *entrusted* (entrustment decision) to perform that EPA unsupervised. For Interns, the level of entrustment is: 'supervision at a distance'.

### **The three components of the new Intern curriculum model (adapted from the Royal Australasian College of Physicians model) the 'Know' 'Do' 'Be':**

**'Know'**: ability to integrate into practice, and to commit to the lifelong learning of a significant body of evolving knowledge.

**'Do'**: essential work tasks trainees need to gain competence in, perform safely, and be entrusted by their supervisors to do in the workplace.

**'Be'**: the professional behaviours, values and practices expected of a trainee as they adopt the professional identity of a physician.

### **Theme**

A concept or topic around which learning is structured. Many related themes are housed under a domain. Themes relate to a group of competencies. For e.g., Domain: *Communication*; Theme: *communication with patients, families, and carers*; competencies for this theme: *use effective*

*appropriate verbal, non-verbal and written communication skills at all times; communicate effectively, collaboratively, and empathetically with patients and carers.*

## Executive Summary

A competency-based approach to medical education has become the international standard approach for medical training to support the highest standards for patient safety and quality of care. The Medical Council of Ireland (MCI) and Medical Intern Board (MIB) have approved entrustable professional activities (EPAs) as the means for delivering competency-based medical education (CBME) for Interns in Ireland. EPAs focus on the performance of essential workplace tasks and the core range of medical and professional knowledge, skills and attitudes that support them. EPAs enable competency committees to make entrustment decisions informing progression to independent practice. The MIB and National Doctors Training and Planning (NDTP) state that the EPAs are the “cornerstone of the curriculum framework” (Offiah & Boland, 2020). While EPAs facilitate entrustment decisions based on knowledge and skills, they do not address multiple key competencies for professionalism. This gap is critical as the MCI identify that “professionalism is at the core of the patient – doctor relationship and is absolutely fundamental for patient safety and the delivery of high-quality health care” (Medical Council, Guide to Professional Conduct and Ethics 8th ed. amended, 2019). The inherent value of CBME can be enhanced by ensuring that all competencies for professionalism are addressed and integrated into the new Intern curriculum.

The ‘Be, Do, Know’ curriculum model has been adopted from the Royal Australasian College of Physicians (RACP) to facilitate the implementation of EPAs. The RACP model comprises of curricula standards that outline the educational objectives of the Australasian training programme for physicians. The ‘Do’ component is delivered by EPAs. The ‘Know’ component comprises of a set of knowledge guides. The ‘Be’ component comprises of the professional behaviours, values and practices expected of a trainee as they adopt the professional identity of a physician (Curricula Standards, 2020).

A project was undertaken to develop a template and content for the ‘Be’ component of the Irish Intern curriculum. The proposed template and content for the ‘Be’ was informed by an extensive literature review, appraisal of current Intern guidebooks and the National Intern Training Programme curriculum (created in 2011), international benchmarking, and feedback from key stakeholders including a patient representative, and national and international experts. A detailed analysis of Medical Council frameworks and documents relating to professionalism informed this process.

The Medical Council’s *Eight Domains of Good Professional Practice* was proposed to the NDTP by the project lead in 2019 as the framework that best aligned with international equivalents. This was selected as the recommended template to underpin the ‘Be’ component pending external stakeholder validation. During the validation process, stakeholder consensus emphasized the need for a singular framework that reflects the competencies for professionalism across the learning continuum, from universities to

training bodies and throughout lifelong professional practice (Continued Professional Development). The *Eight Domains of Good Professional Practice* was identified as the most appropriate framework, with suggestions for additions and revisions (such as *physician self-care, cultural sensitivity, sustainability*). This process revealed that the Medical Council's *Three Pillars of Professionalism* were deemed redundant and open to variable interpretation.

All stakeholders agreed on the urgent imperative to implement CBME. EPAs have been approved by the MIB and Medical Council which will address the 'Do' and 'Know' elements of the revised Intern curriculum. Conversely, while EPAs address the demonstrable behaviours of professionalism (the 'Be') such as *accurate documentation of notes, collaboration, communication*, national stakeholders recognized that multiple competencies of the 'Be' are not addressed such as: *integrity, insight and recognizing limits, humility, compassion, openness, reliability, cultural sensitivity, situational awareness, contentiousness, patient centeredness*. This is consistent with the literature review and expert international opinion.

CBME was borne out of the demand from society and by extension the Medical Council, for accountability to ensure competency in physicians. However, professional behaviours, values, attitudes, and attributes (the 'Be'), extend beyond the limitations of task-based competence and are equally essential to delivering high quality and equitable care. This is best understood through the process of professional identity formation, whereby a trainee is socialized into a community of practice. This process stems from developmental psychology and socio-cultural theories of learning which are well recognized in the literature. During this process a trainee internalizes a profession's core values and beliefs along with their own. A trainee's professional identity encompasses both how others perceive the trainee and how the trainee perceives themselves. A trainee is thus shaped by their personal beliefs, values, and experiences, and by the values and norms that are reflected in the environment (a trainee's community of practice).

*The task of medical education is to "shape the novice into the effective practitioner of medicine, to give him the best available knowledge and skills, and to provide him with a professional identity so that he comes to think, act, and feel like a physician."*  
(Merton 1957, as cited in Cruess et al., 2016)

Professional identity formation is recognized as a core objective of health professions education across multiple international jurisdictions. The 2010 Carnegie report (published by the Carnegie Foundation - a North American Foundation for the Advancement of Teaching guiding medical education reform over the past 100 years), emphasized the development of professional identity formation for medical trainees as one of four key recommendations. While the need for professional identity formation has been clearly established, the process for integration within CBME remains challenging and is currently being explored by the International Competency-Based Medical Education collaborators.

Similarly, the optimum means for integrating professional identity formation within the Irish context has yet to be fully determined.

To reflect the importance of professional identity formation in physician professional development, this report recommends that it be incorporated explicitly within the regulatory code of practice as outlined in the Medical Council's *Eight Domains of Good Professional Practice*. This would mandate professional identity formation as a learning objective across universities and training bodies.

Professional identity formation conceptually aligns with the 'Be' component of the proposed 'Be, Know, Do' outline approved by the MIB/NDTP. To best reflect the development of 'professionalism' it is proposed that the Irish adaptation of the RACP curriculum model be referred to as the 'Know, Do, *Be*' model (as opposed to the RACP 'Be, Do, Know'). This conceptually highlights the progression from knowledge to practice based activity, to *BE*coming a physician.

It is widely accepted that assessment drives learning and motivates learner engagement. There is however no means to directly assess professional identity formation via EPAs or current workplace-based tools. This was established by expert opinion and literature review. Formalizing the process of assessing '*engagement*' in professional identity formation is a feasible initial step. Various teaching strategies to deliver professional identity formation within clinical training have been explored in the literature. These strategies include establishing a cognitive base for professionalism and professional identity formation with interactive lectures, engaging in think-pair-share and quarterly self-reflection exercises, expert facilitated vignette-based case discussions, written and small group guided reflective practice, formal mentorship programmes, training for role modelling and explicit curricula on cultivating mindfulness and compassion. While the impact on patient care has yet to be confirmed in the literature, the above methods are associated with high trainee satisfaction, with a significant improvement in trainee understanding of professionalism, more meaningful engagement with reflective practice, improvement in well-being, and a greater sense of control over personal development of professional identity for both trainee and trainer.

Assessment tools for trainee progression towards professional identity formation were identified by literature review and expert stakeholder feedback. These include Learning Logs and Portfolios, Identity Status Interviews, Professional Self-Identity Questionnaires, Professional Role Orientation Inventories, Professional Identity Essays. Other assessment strategies involve the Longitudinal Professionalism Assessment Tool, Professionalism Mini-Evaluation Exercise, the use of Narratives, and Multi-Source Feedback from medical students, support staff, trainers, peers, and patients. Multi-Source Feedback was viewed by stakeholders as valuable yet potentially challenging within the Irish context. The medical community in Ireland is comparably smaller than counterparts in the US, UK and Australia and concerns regarding discretion and bias were highlighted. Similarly, within

an Irish context, not all teaching strategies are practical for implementation, in particular longitudinal mentorship in the context of a rotational and short 12-month Internship and a scarcity of protected teaching time. A more detailed analysis of teaching and assessment tools extends beyond the scope of this project. A pilot study is underway to inform on viable teaching strategies for implementing professional identity formation in Ireland.

Implementation of professional identity formation will require a body of work for faculty development. Within the Irish context, a snowballing approach to ‘train the trainer’ is most feasible. Training a broad faculty of clinician educators needs a staged approach, initially targeting those clinicians with medical education credentials, in addition to those with an interest and expertise to create a critical mass. Faculty training can foster a shared mental model for professional identity formation and promote change in institutional culture improving the training environment for Interns and retention of doctors. The integration of professional identity formation within the new competency-based Intern curriculum will ensure that the more nuanced and often implicit competencies for professionalism are *explicitly* addressed. This will inform and enhance entrustment-based competency decisions with the central goal of improving patient safety and quality of care.

Just as the introduction of new competency-based frameworks transformed medical education globally, the revision of the national Intern curriculum provides Ireland with an innovative prospect. The integration of professional identity formation into the Irish framework offers a ground-breaking opportunity to the Medical Council as the accrediting body, to place Ireland at the forefront of medical education, demonstrating a commitment to truly foster professionalism and professional identity formation for all physicians across the continuum of training.

## Introduction

### Timeline and background of Intern curriculum preceding this project

The national Internship curriculum has undergone significant revisions as part of the National Doctors Training and Planning (NDTP) *Modernization of the National Intern Programme* project. The overall aim of the revision of the Intern curriculum is to support the transition of the current time-based training model to a competency-based approach and to facilitate the implementation of Entrustable Professional Activities (EPAs) which have been approved by the Medical Council and the Medical Intern Board (MIB). This transition will align the Irish Intern curriculum with international best practice and ensure, upon completion of the Internship year, that trainees have achieved a satisfactory level of competency necessary for safe and effective patient care. The timeline for the development of the Intern curriculum is outlined in **Appendix A**.

### Entrustable professional activities

EPAs for the Internship year were developed throughout 2015 - 2017, culminating in the creation of seven new EPAs for Interns (Byrne, et al., 2018). In August 2016, the new EPAs were adopted by the Medical Council and National Doctors Training and Planning to support a competency-based training programme for Interns. In December 2018, the Medical Intern Board subsequently approved a new curricular model adopted from the Royal Australasian College of Physicians Curricula Standards model known as the “Be, Do, Know” model (Curricula Standards, 2020) and described EPAs as the “cornerstone of the curriculum framework” (Offiah & Boland, 2020, p. 2).

For a sample of an Intern EPA see **Appendix B**.

### ‘Be, Know, Do’ curriculum model

The newly adopted curriculum model initially presented as the *‘Be, Know, ‘Do’ framework* (**Figure 1**) comprises of three components:

**‘Be’** – the professional competencies (professional behaviours, values and practices).

**‘Know’** – the core clinical knowledge across various specialties.

**‘Do’** – the essential work tasks (EPAs) that Interns must gain confidence in, perform safely, and be entrusted by their trainers to do within the workplace.

The content for the 'Do' component of the revised curriculum was published in 2018, in the format of seven targeted EPAs (Byrne, et al., 2018). The 'Be, Know, Do' curriculum outline was chosen because it provided a suitable framework for implementation of these EPAs. The 'Be' and the 'Know' components however, had yet to be developed and a Curriculum Working Group was established to progress this workflow.



Figure 1. The new curriculum model for the Intern curriculum (adopted from the RACP model)  
Image reproduced from the National Curriculum for Internship: Consultation Document - December 2020 (Offiah & Boland, 2020)

## Curriculum Working Group

In February 2019, subject matter experts were voluntarily recruited from members of the six Intern networks to steer the development of the 'Be' and 'Know' components of the new curriculum. Membership of the Curriculum Working Group was as follows:

- NDTP clinical lead – Dr. Gozie Offiah
- Independent educational consultant – Dr. Josephine Boland
- Intern network tutor (volunteer) 'Be' Lead – Dr. Natasha Slattery
- Intern network tutor (volunteer) 'Know' Lead – Dr. Orla Mongan
- Senior House Officer (volunteer) – Dr. Elaine Walsh

Work was completed within and outside of normal working hours, with multiple meetings in Dublin, Galway and Limerick from June to November 2019 (Offiah & Boland, 2020).

During this time, curriculum development work was carried out and presented by each lead on their respective component.

### NDTP/MIB Framework consultation process

Identification of the Medical Council *Eight Domains of Good Professional Practice* as a template for the 'Be' component of the Intern curriculum was proposed by the 'Be' lead with development of an initial draft (content and themes) by the 'Be' lead for subsequent review and feedback from the working group. Sample extracts of the first draft of the proposed 'Be' template were presented by the NDTP and Chair of the MIB at the MIB/NDTP National Curriculum for Internship Consultation Workshop via Zoom in December 2020. The purpose of the consultation was to introduce the 'Know, Do, Be' framework, engage with national stakeholders and obtain early phase feedback on the curriculum project (Offiah & Boland, 2020, pp. 22-23).

### NDTP funding

In December 2019, the 'Be' lead applied for NDTP development funding to support wider national and international stakeholder engagement across universities, training bodies and networks. This was to ensure that the proposed template and content for the 'Be' component appropriately reflected both benchmarked standards and key stakeholder views from within an Irish context. The project was approved for funding in December 2019. A detailed summary of the funding timeline is outlined in **Appendix B**.

### Purpose and project outputs

The purpose of this project was to:

1. Inform the development of the 'Be' component of the Intern curriculum.
2. Disseminate to national stakeholders and take feedback at a formative stage of curriculum development.
3. Engage with stakeholders to ensure that their views can be incorporated to facilitate their future engagement in the implementation of the curriculum.
4. Integration of feedback from national and international experts to optimize and validate the curriculum framework and content.
5. Benchmark and ensure a comprehensive revision of the proposed curriculum framework guided by international best practices.

The specific outcomes of this project in relation to the 'Be' component of the curriculum are outlined here as specified in the NDTP Development Funding proposal.

1. Ensure national stakeholder engagement.

2. Ensure a consensus within an Irish context for the development of the 'Be' component.
3. Ensure incorporation of national and international expertise in the development of the 'Be' element.
4. Support the development of a competency-based curriculum based on best international practice.
5. 'Modernize' the Intern curriculum in relation to the 'Be' component and ensure a comparable experience for all Irish Interns irrespective of network placement.

## Methodology Phase 1

### Overview

At the outset, of central importance was an evidenced based approach and dedicated face-to-face engagement with key stakeholders along with expert national and international speakers via workshops and discussions. This methodology was undertaken to ensure that the final template and content for the 'Be' element would be of high quality, informed, applicable, and sustainable.

- **Quality:** template and content benchmarked to international equivalents and aligned with best practice
- **Informed:** stakeholder engagement with international experts with experience in competency-based curricula programmes established since the early 1990s
- **Applicable:** template and content informed by an Irish context (feedback from key stakeholders at the 'coalface' of delivering or receiving Intern training)
- **Sustainable:** the Intern year establishes direction for medical schools and serves as the foundation for subsequent higher training years. As such, the proposed 'Be' template and content should facilitate and support the competencies for 'professionalism' required along the entire continuum of training and throughout professional practice.

### Project activities

The following activities were completed to achieve the project's intended outcomes. An iterative process was undertaken with adaptations as required made to project plans and methodology based on expert feedback and in response to unanticipated challenges (e.g., Covid-19 related restrictions and lockdown):

- Review of existing frameworks
- Review of Intern Network Guidebooks

- Literature review of international best practices in competency-based medical curricula for first year doctors
- Benchmarking framework against international frameworks
- Mapping and blueprinting
- Consultation with International experts and curation of themes for discussion
- Engagement of national key stakeholders
- Focus groups and workshops informed by best practice using qualitative research methodology
- Liaise, collate, and integrate feedback from all key stakeholders
- Project dissemination via national and international presentations: Institute of Medicine, RCPI (January 2022), Canadian Conference on Medical Education (April 2022), Cork University Hospital Grand Rounds (April 2022), University of Limerick - Faculty Development workshop (February 2022). These presentations and discussions informed development
- Preparation of a consensus report based on stakeholder feedback

### Existing national frameworks – a review

A review of existing Irish frameworks was performed to inform the development of the 'Be' template. Two frameworks were identified:

1. The Medical Council's *Eight Domains of Good Professional Practice*
2. The Medical Council's *Three Pillars of Professionalism*

In CBME, competencies that underlie a programme's outcomes are collectively anchored to an organizing framework that describes both the required and the desired qualities of physicians. This organizing framework should provide overall guidance for trainees, trainers, and institution. As such, the development of a template to organize and inform the 'Be' competencies required careful consideration. An organizing 'Be' template for the Intern curriculum would need to encompass aspects of the RACP curriculum outline (adopted by the MIB for the new Intern curriculum) while also acknowledging and aligning with the frameworks for professionalism already established within Ireland.

The first of such frameworks is the Medical Council's *Eight Domains of Good Professional Practice framework (Figure 2)*, devised in 2010 (Medical Council, Good Professional Practice, 2010). The absolute integration of this framework was of particular significance as the Medical Council's *Eight Domains of Good Professional Practice* describe competencies applicable to all registered medical practitioners *across the continuum of professional development* from undergraduate to post graduate subspecialty training, and throughout maintenance of professional competence. Of note, for example, when recording Continuing Professional Development (CPD) credits, physicians are prompted to indicate which of the Eight Domains a CPD activity correlates with. Similarly, the

professional competencies outlined in ‘Be’ needed to reflect the professional competencies expected across all training programmes and CPD schemes.



Figure 2. Medical Council's *Eight Domains of Good Professional Practice*  
For a detailed outline see **Appendix D**.

The Medical Council's *Three Pillars of Professionalism* (**Figure 3**) provides a further Irish framework for professionalism and incorporates the *Eight Domains of Good Professional Practice*. The Three Pillars of Professionalism, launched by the MCI in 2016 is currently published under the "Professionalism" chapter of the MCI's amended Guide to Professional Conduct and Ethics for Registered Medical Practitioners 8<sup>th</sup> ed. (p.10). The establishment of the Three Pillars of Professionalism serves to provide "extended guidance on professionalism" by reflecting the values, principles and behaviours "we expect of all doctors from the moment they enter medical school right through until retirement, so that the highest possible standard of care is provided to patients" (Medical Council, Guide to Professional Conduct and Ethics, 2016, p. 5).



Comhairle na nDoctúirí Leighis  
Medical Council

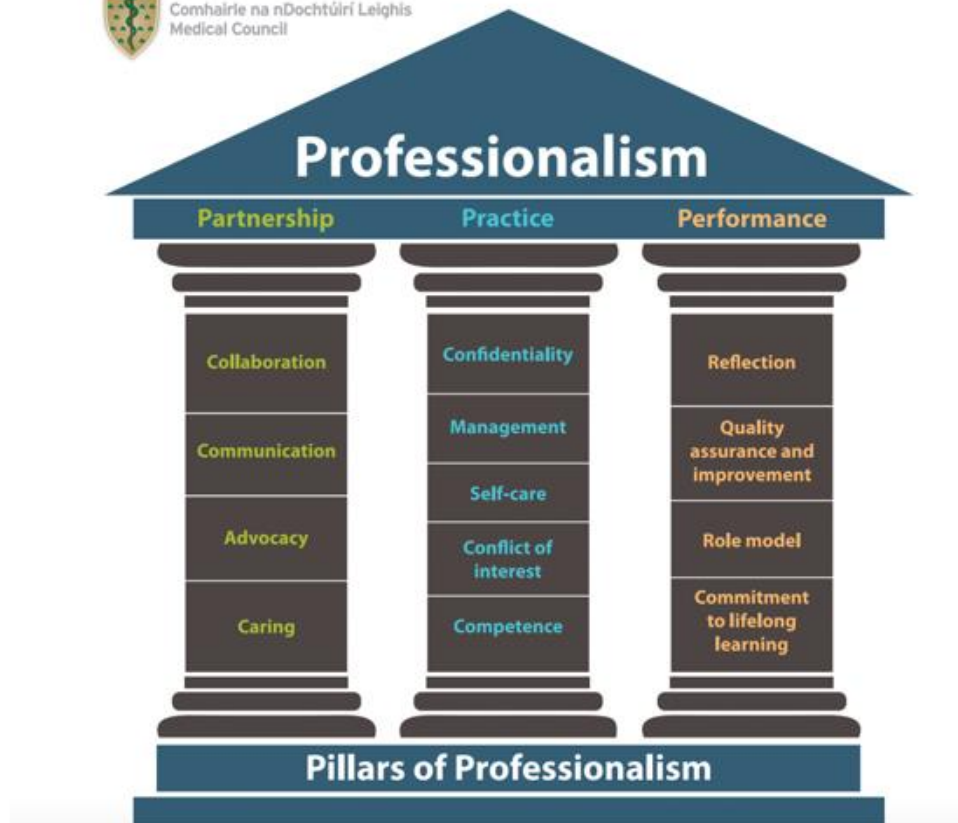


Figure 3. Medical Council's *Three Pillars of Professionalism*. For a detailed outline see **Appendix E**.

It was important that the 'Be' template align with both existing frameworks and reflect contemporary changes from the continuous evolution of medical professionalism. To ensure best practice, a 3-stage approach was undertaken:

- Stage 1. A review of guidebooks and literature.
- Stage 2. Benchmarking template against international equivalents.
- Stage 3. Expert international and key stakeholder feedback on the template.

### Intern network guidebooks – a review

Each of the six Intern networks have developed a teaching programme and guidebook materials based on the Internship programme as outlined in the National Intern Training Programme. A review of Intern guidebooks was performed to deliver an overview of the competencies of professionalism addressed across current Intern Network curricula and to determine the extent of integration of professional identity formation within the Intern curricula nationally. The review demonstrated that professional identity formation for Interns is not formally addressed during the Internship year. Teaching of professionalism

during the Intern year primarily addresses the medico-legal aspects of this core competency.

## Literature review

A review of relevant literature to appraise the benefits and pitfalls of CBME in postgraduate training was performed. An extensive search was subsequently performed with the expressed intention of exploring the integration of professionalism and professional identity within CBME in postgraduate training programmes internationally.

Over the past hundred years, the Carnegie foundation for the advancement of teaching has twice called for the reform of medical education. The first call heralded by the *Flexner Report* in 1910 (Flexner & Pritchett, 1910) and the second with *Educating Physicians: A Call for Reform of Medical School and Residency* in 2010 (Cooke, Irby, & O'Brien, 2010). Four key points were highlighted including a call for “standardizing learning outcomes and individualizing the learning process,” and a “major” focus to be placed on professional identity formation (Cooke, Irby, & O'Brien, 2010, pp. 5-6). The report stated that one of the key goals of medical education was to foster and facilitate the development of professional identity in medical students and residents. Yet more than 20 years since its publication, a lack of explicit integration of professional identity formation in competency-based postgraduate programmes remains (O'Brien & Irby, 2013; Pock, Durning, Gilliland, & Pangaro, 2019).

The ensuing paucity of evidence in the literature prompted the ‘Be’ lead to explore with international experts how professional identity formation was integrated within competency based programmes at other institutions. The purpose was to better inform approaches for how to address ‘gaps’.

## Benchmarking

### International Frameworks

Benchmarking of international frameworks supported the development of the proposed template and content for the ‘Be’ component of the curriculum. This approach enabled an alignment with best practice to ensure that the ‘Be’ template and competencies respond to up-to-date developments in medicine and reflect a contemporary set of standards.

Focus was placed on the following frameworks:

- The **Royal Australasian College of Physicians, RACP Professional Practice Framework (Figure 4)** (Professional Practice Framework, 2020) was selected for benchmarking in light of the NDTP/MIB adoption of the RACP Curricular Standards outline, the 'Be Do Know' (Curricula Standards, 2020) for the Intern curriculum



Figure 4. RACP Professional Practice Framework

- The **Canadian Medical Education Directives for Specialists, CanMeds framework (Figure 5)** (CanMEDS: Better standards, better physicians, better care, 2022) was selected for benchmarking for several reasons:
  - the model has been consistently revised since officially launching in 1996 (currently on 3<sup>rd</sup> revision)
  - it is the most widely applied competency framework in the world for physicians with implementation in dozens of countries over five continents (RCPS, CanMEDS About History, 2022)
  - the CanMEDS framework has supported the implementation of EPAs in almost all Canadian medical specialties
  - it is worth noting that the RACP framework – the ‘Be, Do, Know’ (approved by the NDTP/MIB as the new framework for the Internship year) was adapted from CanMEDS 2015

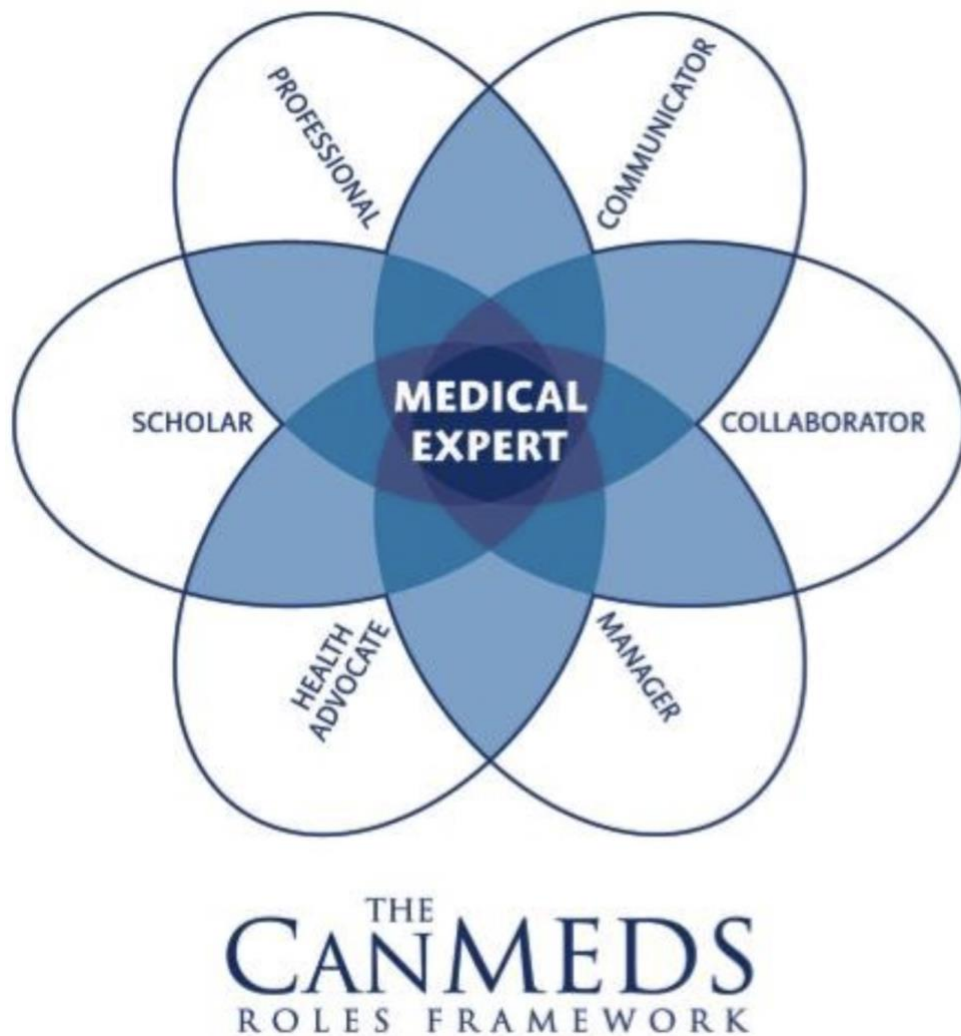


Figure 5. CanMeds framework

- The **American Accreditation Council for Graduate Medical Education, ACGME Core Competencies (Figure 6)** framework was selected for continuity, as the development of EPAs for Internship year were benchmarked against the Association of American Medical Colleges EPAs, with significant alignment noted. These are the core US medical student EPAs completed prior to entering residency (Winn, et al., 2016). The ACGME framework outlines six core competencies which define the foundational skills expected of residents and provides the structural framework for the competencies depicted in EPAs (ACGME, Accreditation Council for Graduate Medical Education, 2022; Standards for Initial Certification, 2016).

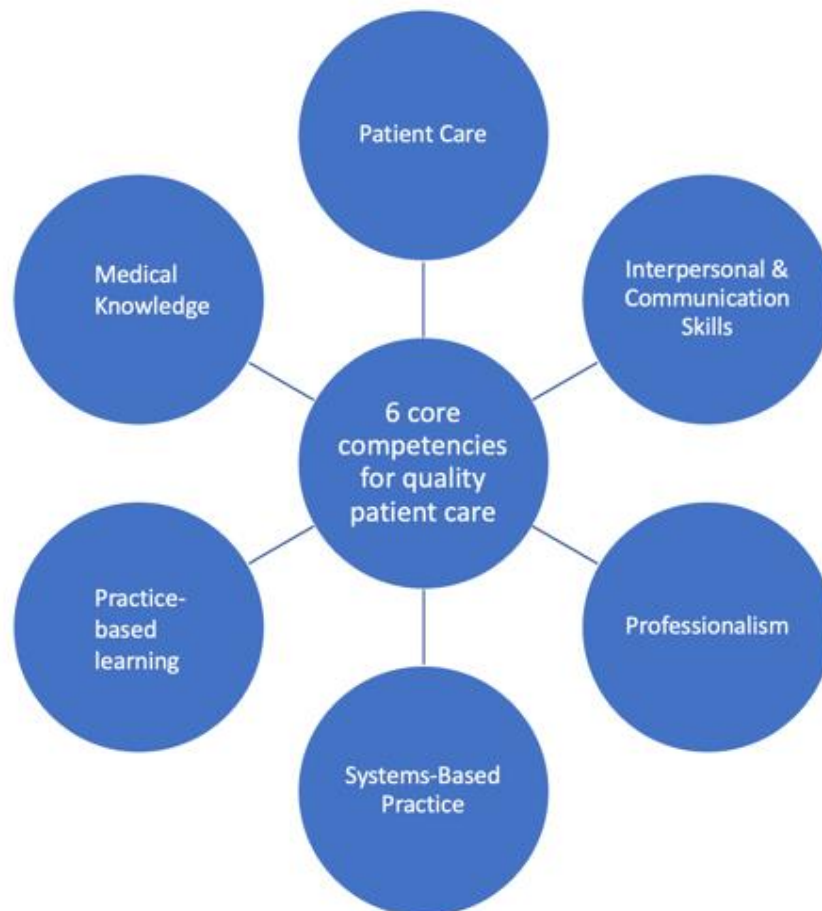


Figure 6. ACGME 6 Core Competencies

## Irish Frameworks

A review of the 3 frameworks demonstrates the high alignment of the Medical Council's *Eight Domains of Good Professional Practice* to international equivalents. Overall, there remains a strong alignment between the MCI's Eight Domains of Good Professional Practice with all three of the frameworks, in particular the CanMEDS and RACP frameworks. As such, the *Eight Domains of Good Professional Practice* was selected as the basis for the initial template for the 'Be' component of the curriculum. For details of the benchmarking exercise see **Appendix D**.

In summary, this project was informed by a review of existing frameworks (Medical Council's *Eight Domains of Good Professional Practice* and *Three Pillars of Professionalism*), the Intern guidebooks, the literature, and the framework benchmarking exercise. This exercise revealed that the incorporation of the MCI's *Eight Domains of Good Professional Practice* into the 'Be' template warranted further revision to better reflect current societal needs and the delivery of medicine in present-day settings. Evidence of this is noted in the lack of domains for *cultural competency, diagnostic reasoning and inquiry, pandemic/major emergency response/global health, sustainable healthcare*. These are a sample of the potential domains that have emerged as necessary responses to new needs identified by members of the public and the profession, and to ever evolving global healthcare and environmental needs. Of note, while professionalism was addressed across all frameworks, none of the frameworks *explicitly* included professional identity formation.

There was significant overlap between the *Three Pillars of Professionalism* and the *Eight Domains of Good Professional Practice*. The *Three Pillars of Professionalism* included the additional elements of *social media, equality and diversity, doctors in management roles* which were originally conceived by the Medical Council in response to feedback from the public and the profession, from healthcare organizations, and from a review of complaints over a five year period (Medical Council, Guide to Professional Conduct and Ethics, 2016). These elements were incorporated into the 'Be' template.

## Proposed nine domains for the 'Be' template

Nine final domains were selected and revised for the draft 'Be' template and presented to stakeholders (**Table 1**). Each of the nine domains were further divided into themes, and each theme was associated with several competencies. Each of the domains were grouped to align with one of the three 'Pillars of Professionalism' (*Partnership, Practice or Performance*). The 'principles' and 'values' detailed within the Medical Council's *Three Pillars* were incorporated within the draft 'Be' template. This was undertaken to ensure a comprehensive reflection of the feedback from the public and the profession.

The *Clinical skills* domain was renamed *Medical Expert* to reflect international benchmarked standards (CanMEDs and RACP). This broader term encompasses the clinical skills as currently outlined. The domain for *Relating to Patients* was revised to *Patient Centred Care* and the domain for *Professionalism* was revised to *Professional Conduct and Ethics*.

An additional domain was incorporated into the draft ‘Be’ template, *Physician Well-Being*. This was a revision of the Medical Council’s *Management (including Self-Management)* domain. The serious impact of physician burnout and poor well-being on the quality of patient care, other healthcare providers, the healthcare system and society is recognized (The Medical Protection Society, 2019). As a result, it was proposed that *Self-Management* becomes *Physician Well-Being*.

The revised draft of the proposed ‘Be’ template presented at the National Stakeholder conference is provided in **Appendix G**. This was created as a sample template on which to base a final draft. During stakeholder discussions (stage 3 of the project) several new domains were selected for specific feedback from stakeholders. These include the following: *cultural competency, diagnostic reasoning and inquiry, health policy and systems, global health, sustainability*.

**Table 1.** Proposed Nine Domains for ‘Be’ Template

Nine Proposed Domains for ‘Be’ Template	Medical Council 8 Domains of Good Professional Practice
Patient Safety and Quality of Care	Patient Safety and Quality of Care
Patient Centred Care	Relating to Patients
Communication	Communication and Interpersonal Skills
Collaboration	Collaboration and Teamwork
Ethics and Professional Conduct	Professionalism
Management	Management (including Self-Management)
Physician Well-Being	-
Scholarship	Scholarship
Medical Expertise	Clinical Skills

## Mapping and blueprinting competencies for professionalism (‘Be’): Process

### Mapping competencies for professionalism (‘Be’)

Mapping and blueprinting were undertaken in an iterative manner with multiple updates and revisions of the proposed ‘Be’ template based on feedback. This exercise took place in advance of the conference during interviews and focus groups (with national experts) and Curriculum Working Group discussions.

The initial 'Be' competencies were mapped to the seven Intern EPAs to minimize any duplications and identify gaps by the Curriculum Working Group (GO, JB, NS, OM). The mapping process streamlines the mapping of a particular competency to the most relevant EPA and specifically identifies 'Be' competencies which are not addressed within an EPA. The mapping exercise revealed that several 'Be' competencies were only implicitly associated with an EPA while others did not map at all.

#### Blueprinting competencies for professionalism ('Be')

Initial blueprinting was undertaken to identify appropriate and validated workplace-based assessment (WBA) tools for each competency. This was commenced by members of the Curriculum Working Group (GO & JB) and progressed by the 'Be' lead. The blueprinting process was analysed by the 'Be' lead in the context of the international literature. The results of this analysis showed comparatively fewer workplace-based assessment tools for the implicit 'Be' competencies in comparison to the explicit 'Be' competencies.

#### Mapping and blueprinting competencies for professionalism ('Be'): Results

Mapping and blueprinting revealed that explicit demonstrable competencies for professionalism were easily mapped. For example, the competency for *timely and accurate documentation* explicitly maps to all seven Intern EPAs (e.g., EPA 1: Admit a patient; EPA 2: Request and interpret common investigations; EPA 3: Perform basic procedural skills; EPA 4, etc.). Other competencies such as *"promotes patient's preferences and autonomy as central to the provision of high-quality care; adheres to IMC ethical guidelines on social media; takes responsibility for personal health, well-being and performance"* fail to map to any of the seven EPAs. The competency of *"adopts a holistic and patient centred approach to care"* mapped explicitly to three EPAs and only implicitly to three other EPAs; *"maintains confidentiality in all aspects of patient care"* maps explicitly to two EPAs and maps *implicitly* to five EPAs.

Integral patient centred care competencies that are only *implicitly* implied via EPAs may not be effectively conveyed to Interns. As a result, while *explicit* competencies are *assessed*, *implicit* competencies can only be *assumed*. This lies in stark contrast to the purpose of a competency-based approach which is to continuously assess for competency as opposed to *assuming* it upon completion of pre-set duration of time. Assessment of implicit competencies by trainers which do not map to EPAs is potentially more difficult and prone to subjectivity.

NDTP identified five workplace-based assessment tools for use with EPAs (Offiah & Boland, 2020). A blueprinting exercise revealed that only one (reflective journal) was

identified as a potential tool for assessing the implicit or ‘gap’ competencies. For a list of WBA tools and definitions see **Appendix H**. It is notable, that the reflective journal is the only workplace-based assessment tool (of the five listed) that takes places *outside* of the clinical setting and *without* trainer guidance.

Many of the implicitly mapped or ‘gap’ competencies such as: *honesty, integrity, confidentiality, reliability, cultural sensitivity, openness, compassion, accountability, and insight* are inherently necessary to professionalism as identified by over 90% of the public (Medical Council, Talking about good professional practice: Views on what it means to be a good doctor., 2014). Similar feedback was provided during this project by most stakeholders and was emphasized as critical by the patient representative. Supporting professional identity formation provides a means by which such competencies are identified to Interns as being important. The assessing of these competencies with validated tools is also essential with the acknowledgment that assessment drives and engages learning.

### Engagement of international experts and conception of themes for discussion

The extensive literature review facilitated the identification of five renowned subject matter international experts from Europe and North America; Olle ten Cate, Richard Cruess and Sylvia Cruess, Robert Sternszus and Stan Hamstra. The international experts were purposely selected for the transformational advancements they have progressed in medical education (in the field of CBME, EPAs, professionalism and professional identity formation, teaching, and assessment). The aim of their involvement was to gain broad insight from their rich perspectives on all aspects of curricula development; from the integration and assessment of professionalism in competency-based post graduate programmes, to strategies for implementation.

The experts were individually contacted with the express view of exploring various interpretations of ‘Be’ competencies, the integration of professionalism and professional identity formation in competency-based programmes and the role of professionalism in EPAs and entrustment decisions. The themes for discussion were conceived by the project lead and addressed in the invitations to each expert. Discussions and debates took place with the experts via multiple Zoom meetings over a five-month period; each meeting further informing an aspect of the ‘Be’ component of the curriculum. For a detailed biography of all international experts please see **Appendix I**.

### Discussion

The experts confirmed that it was not possible to create an EPA for professionalism. Expert consensus highlighted the value of professional identity formation for trainees. The experts agreed that a ‘Be’ could not be a ‘Do’. In other words, an EPA cannot comprehensively address all ‘Be’ competencies and therefore significant ‘gaps’ exist for

professional competencies which are more nuanced or implied. The experts concurred that EPA entrustment decisions were complex and depended on both explicit competencies demonstrated via WBA tools and on more nuanced variables such as *trust, humility, insight, reliability, and agency*.

The international experts concurred that this project and conference had introduced a novel dialogue highlighting how the integration of professional identity formation had yet to be fully realized within competency-based programmes. Many of these programmes are currently engaged in the second (and in some cases third) revision of their frameworks.

Following the conference, the experts identified the value of this discourse and prompted its dissemination to a wider international platform. The 'Be' lead was invited to deliver a 90-minute workshop addressing the integration of PIF within CBME at the Canadian Conference for Medical Education and the International Conference on Residency Education in collaboration with the experts. A similar dialogue was also shared at a subsequent International Collaborators for Competency-Based Medical Education meeting.

## Engagement of national key stakeholders

### Key stakeholders

A two-day conference was conceived to facilitate face-to-face engagement with national key stakeholders. These comprised of members from the Medical Council and NDTP, multiple Training Body Leads (ICGP, RCPI, RCSI), Medical School Deans, sub-specialty Training Leads, Non-Consultant Hospital Doctors (two who had recently completed Internship and three with Master/PhD qualifications in medical education), Clinical Trainers, Clinical Tutors, and Clinical Educators from all six training sites. A diverse array of stakeholder feedback was essential to ensure that the proposed 'Be' component was relevant, applicable, and sustainable. Multiple specialties were represented including, Medicine, Surgery, General Practice, Anaesthesiology, Paediatrics, and Psychiatry. Over 50 key stakeholders were invited for their subject matter expertise across a wide range of specialties, and for their perspectives across the continuum of training. Over 40 key stakeholders attended. Prior to the conference, several interviews and/or focus groups took place amongst Consultant Trainers and educational leaders. A patient representative was interviewed for feedback on the template prior to the conference.

Stakeholders who contributed to interviews, focus groups, and/or the conference are listed in **Appendix J**. Further invitations were extended to include the following: Medical Council, College of Paediatrics, Anaesthesiology, ICGP, RCPI, RCSI, UCD, NUIG, UCC.

## National stakeholder conference for the 'Be' component

A two-day conference was held in Kildare from Friday October 1<sup>st</sup> to 2<sup>nd</sup>, 2021. This conference was conceived with a view to supporting attendance of key stakeholders with the dual purpose of leading the national discussion in this area and obtaining important feedback to progress practice change. Incorporating a faculty development theme and removing stakeholders from the time constraints of clinical commitments ensured a captive audience for face-to-face engagement and feedback. Critical to the development of the 'Be' component was this informed interaction, discussions, and debate.

A total of five talks, three workshops and a plenary session were delivered. A series of informed presentations delivered by the 'Be' lead and experts addressed the following: medicine's progression toward CBME, the new curriculum model, the development of the 'Be' component, the challenges for addressing 'Be' competency 'gaps' with EPAs, the role of professional identity formation, the role of EPAs in professionalism, and teaching and assessment strategies for professional competencies and professional identity formation. Stakeholders were provided with the draft of the 'Be' template and content and a set of questions to discuss over the course of several workshops and interactive sessions. Stakeholders participated in multiple small focus groups facilitated by trained researchers from University of Limerick's Health Research Institute. Large group discussions took place with the international experts chaired by the 'Be' lead. For an outline of the conference talks and a sample of discussion questions see **Appendix K**.

## Methodology Phase 2

### Qualitative study design

A qualitative descriptive design informed the 'Be' component of the curriculum (Sandelowski, 2000). This methodology enabled an understanding of key stakeholder perspectives rooted in those actively delivering or receiving Intern training. Understanding the importance of Internship within the learning continuum, a range of stakeholders were engaged from across the undergraduate to postgraduate spectrum, and across all training networks and universities.

An inductive grounded theoretical approach to the analysis of diverse expert stakeholder views will ensure that final consensus for the proposed 'Be' component is relevant, applicable, and sustainable. Active engagement of stakeholders in the curriculum development process for the 'Be' template will ensure future support for implementation or adaptation.

## Data collection

Data was collected via:

- audio recordings of small groups (5 stakeholders per table)
- large group discussions
- online interactive survey
- participant notes documented on 'Be' templates and notes taken by assigned stakeholder scribes and expert facilitators at each table

Data was audio recorded and anonymously transcribed for coding and thematic analysis, collation and integration of findings as informed by best practice in qualitative research methodology. NDTP Development Funding financed transcription. Coding and analysis were performed by the project lead.

## Data analysis

Over 35 hours of focus group and large group discussions were anonymously transcribed. Coding and thematic analysis, collation, and integration of findings was performed by the 'Be' lead. Research ethical approval was provided from the University of Limerick Hospital Group.

Code and themes were identified from the qualitative analysis of the transcripts and informed the project recommendations and report.

## Integration of Stakeholder Feedback

Stakeholder feedback was collated, analysed, and summarized to provide concise and relevant feedback. For sample excerpts of stakeholder feedback see **Appendix L**.

A summary of the main points is outlined.

There was consensus that the Medical Council's *Eight Domains of Good Professional Practice* provides a comprehensive and relevant framework to underpin the 'Be' competencies.

Stakeholders identified revisions and updates to the *Eight Domains of Good Professional Practice* to ensure that the domains reflect contemporary practice and the needs of patients and society.

There was consensus that the addition of *Cultural Competency* should be

included in a contemporary framework. However, there was no consensus on whether *Cultural Competency* should be included as a domain or in a more limited manner as a theme.

All stakeholders identified *Scholarship* as an important domain for professional practice and life-long learning, enhancing the delivery of patient care. There was, however, a lack of consensus on the domain of *Scholarship*. Stakeholders did not agree on the themes proposed under this domain - specifically in relation to the following themes: *Reflection, Role Modelling, Teaching, Mentorship, Leadership, Life-Long Learning*. Some expressed a view that *Scholarship* appropriately encompassed all themes listed above. Others identified that *Teaching, Role-Modelling* and *Leadership* were not appropriately designated under the domain of *Scholarship*. There was no consensus on an alternative location within the 'Be' template for these themes.

There was consensus that *Teaching* was an important aspect of professional practice and that its inclusion was necessary as a theme with associated competencies developed specifically for the Intern level (for example: peer-peer and near-peer teaching (with fellow colleagues and medical students)).

There was a lack of consensus for *Leadership* as an important theme for Internship. Some considered this an advanced competency that should be developed beyond Internship. More stakeholders agreed that all important competencies need foundational development at an *early* stage.

There was consensus for the inclusion of *Sustainable Health Care*. However, there was a lack of consensus for whether this should stand as additional domain or be included as a theme.

There was consensus for the inclusion of *Physician Well-Being* as a domain. Stakeholders identified *Physician Well-Being* as a priority. There was some debate whether this would be best labelled *Physician Self-Management* as this is a broader term and refers not only to the self-management of a physician's well-being but also other important elements such as *time management*.

There was consensus for potentially new domains such as *Health Policy and Systems* and *Decision Making/Diagnostic Reasoning* to be encompassed as themes within the domain for *Management*.

There was consensus that the themes and competencies associated with the *Medical Expert* domain as proposed in the template, refer to competencies which all fall within the 'Do' (EPAs) and the 'Know' (knowledge guide) components.

There was consensus that *Social Media* be included as a theme, however no consensus was reached on whether this theme and associated competencies should be included within the domain for the following: *Communication, Management, or Ethics and Professional Conduct*.

There was consensus that the themes *Documentation* and *Handover* were already incorporated in EPAs (the 'Do') and should be removed from the 'Be' template to minimize redundancy.

Some stakeholders suggested that for competencies which were identified as critical to safe patient care (e.g. *patient safety, communication, collaboration*), inclusion across both the 'Be' and the 'Do' was warranted.

There was consensus that the Medical Council's *Three Pillars of Professionalism* contained redundancy and were open to variable interpretations. In particular, stakeholders identified significant overlap in definitions for 'Practice' and 'Performance' pillars. However, stakeholders identified a limited number of principles and values which were stated within the *Three Pillars* and not contained within the Medical Council's *Eight Domains*. Stakeholders advised their inclusion within the 'Be' template.

There was stakeholder consensus that a chosen framework for the 'Be' template must underpin practice across the undergraduate to postgraduate continuum, including continued professional development and extend across all training bodies. Within competency-based programmes in universities and training bodies, the outline for the 'Do' (workplace tasks and assessments) and the 'Know' (knowledge) may already be in place, however the translation of the 'Do' and 'Know' into workplace-based competence requires further evolution. Some stakeholders considered that the Intern year should provide confirmation of workplace-based competence (e.g., via EPAs). Whereas others considered these competencies should be confirmed *prior* to commencing Internship. The conflict arises when the service requirements extend beyond the competencies delivered by the undergraduate university programmes.

There was a lack of agreement on the appropriate 'Be' competencies for Interns. There were conflicting views on the threshold and requirements for *readiness to practice* amongst national expert stakeholders; some articulating that many of the competencies should already be achieved *before* commencement of Internship (paid employment). Moreover, stakeholders viewed certain 'Be' competencies as aspirational, whilst others viewed the same competencies as either essential or achievable. For example, some considered the competency "*use resources responsibly while considering the needs of patients*" as an important consideration for Interns (when ordering laboratory tests), but others viewed this as extending

beyond the scope of Intern practice. Similar disagreements were expressed for the following three competencies: 1. *Promote patient's preferences and autonomy as central to the provision of high-quality of care*; 2. *Advocate for fair use of resources for overall benefit of all patients*; 3. *Understand and address patients', families', and carers' physical and emotional needs*. In contrast for other competencies, there was consensus on the threshold of readiness to practice, for example: 1. *Demonstrate a caring attitude towards patient*; 2. *Establish a trusting and respectful partnership between doctor, and patient and between medical profession and society*. Where there were multiple views and lack of consensus, a body of work is required to establish the threshold for some competencies. This body of work extended beyond the scope of this project.

Stakeholders suggested that the 'Be' template be developed from the perspective of a spiral curriculum, with progression from foundational to advanced levels of competencies.

There was consensus that professional identity formation needed to be explicitly integrated within the Intern curriculum. An interactive workshop took place at the stakeholder conference during which a stakeholder survey was undertaken. Professional identity formation was identified as a much stronger influence on an individual's professional development than either virtue-based or behaviour based professional frameworks. This aligns with international literature (Crues, Crues, & Steinert, 2016; Hafferty, 2016).

## Patient Safety

In recognition of the importance of patient safety as an essential aspect of effective health care, nine patient safety domains were mapped to the 'Be' template.

### Mapping of 'Be' template and content to domains of patient safety

The patient safety domains were provided by Professor Dara Byrne to the Curriculum Working Group as part of work in progress. In their current iteration, these domains were as follows: *Culture of safety*; *Patient safety*; *Reliability of Health Care Delivery*; *Care Transitions*; *Improvement methods/systems thinking*; *Performance measurement and transparency*; *Quality of care*; *Medication safety*; *Infection control*. All patient safety domains mapped explicitly to the 'Be' template within either a 'Be' domain or theme except for *Medication Safety*.

It is important to note that while patient safety competencies are covered within EPAs, ensuring comprehensive competence for patient safety can only occur if every Intern experiences *all* patient safety competencies within the workplace (for e.g. EPA 4.16 *Disclosure of adverse events*; EPA 5.16 *Recognize, address, and inform patient, pharmacy and risk managers of medication errors*). As such, additional addressing of patient safety domains is advised for ensuring competency. One could argue that for this critical aspect of health care, these competencies should appear across all three components of the Intern curriculum 'Know' (knowledge), 'Do' (workplace tasks) and 'Be' (professionalism).

## Teaching and Assessment Strategies for Professional Identity Formation

The teaching and assessing of 'Be' competencies extend beyond the scope of the funded project. However, the conference provided a useful opportunity for faculty development for the national educators and trainers in attendance.

International experts delivered presentations on various teaching and assessment strategies for professionalism and professional identity formation, to conference stakeholders. Feedback on teaching and assessment tools were explored during a 90-minute workshop with further deliberations during a large group discussion. Strategies for adapting international tools to the Irish context were discussed. Supports and challenges for the implementation of assessment tools within the Internship year were explored.

In advance of the conference, a dedicated series of Zoom discussions took place to induct the international experts into the context of the Irish internship to inform their presentations.

### Teaching of professionalism

The inclusion of 'professionalism' in competency frameworks (such as ACGME, CanMEDS, RACP) identifies 'professionalism' as a core competency. Similarly, professionalism is included within the *Eight Domains of Good Professional Practice* which underpins the 'Be' template. The inclusion of 'professionalism' necessitates that it must be *explicitly* taught and assessed within the new Intern curriculum. The Royal College of Physicians, London defines *professionalism* as "a set of values, behaviours, and relationships that underpins the trust the public has in doctors" (2005).

The teaching of professionalism is delivered in the Intern year primarily via modules focused on both the medico-legal and ethical aspects of professionalism, and on professionalism as part of medicine's social contract with the public.

## Teaching of professional identity formation

More than 20 years ago, when professionalism was first introduced as a core competency in medical education, the objective was to ensure that professionalism, the profession's values, and demonstration of professional behaviours were taught to trainees. Subsequent literature revealed that medical education's objective was perhaps best focused on supporting trainee professional identity formation instead (Cruess, Cruess, & Steinert, 2016). In simplistic terms, it was assumed that by teaching trainees about professionalism, professional values and expected behaviours, that trainees would automatically 'BEcome' professional. It is now appreciated that a more effective approach may be to support Interns to actively engage in and reflect upon the tensions and challenges that they experience as they progress through the Intern year; to reflect upon the processes that transform them into *acting, thinking, and feeling* like the physicians they aspire to be.

In this capacity, the international experts advised that in addition to teaching professionalism, a cognitive base introducing the process of identity formation for Interns must be established. Professional identity formation describes the process by which a trainee internalises a profession's core values and beliefs along with their own.

A trainee is thus shaped by their personal beliefs, values, and experiences, and by the values and norms that are reflected in the environment (socialisation into a community of practice). A trainee's professional identity encompasses both how others perceive the trainee and how the trainee perceives themselves. It is widely recognised that the teaching and assessment of 'professionalism' is challenging. Integrating professional identity formation within the Intern curriculum provides a means by which to address this challenge. Professional identity formation has been integrated into undergraduate and postgraduate settings in other jurisdictions (Cruess, Cruess, & Steinert, 2016).

Teaching methods for professional identity formation include near-peer small group sessions (the use of vignettes to initiate guided reflection and discussion), quarterly self-reflection exercises (Interns rate their 'journey to becoming a doctor' on a numeric scale which serves as a prompt for guided self-reflection and discussion), formal mentorship programmes, role modelling and explicit sessions on cultivating mindfulness and compassion. At present, professional identity formation is not addressed in the Intern year. Most stakeholders recognised the value of addressing professional identity formation within the Intern curriculum but also identified the challenges involved with the teaching and assessment of professional identity formation.

## Stakeholder feedback on teaching

Stakeholders participated in a workshop to explore methods to integrate professional identity formation into the Intern curriculum. Stakeholders identified several teaching methods which were feasible for implementation within the Intern year. There was general agreement that delivery of large group teaching sessions for professional identity formation and professionalism was a practical means to establish a cognitive base for the Interns. Stakeholders also concurred with the benefits gained from teaching methods such as mentoring, role modelling, near-peer groups, mindfulness, and compassion sessions. It was acknowledged that over the past three years sessions had taken place both locally and nationally to address trainee mindfulness with mixed reception. Most stakeholders were highly receptive to the use of quarterly self-reflective exercises and near-peer groups. Suggestions were made to incorporate these during periods of Intern transition which were identified as the change of specialty rotations (e.g., from medicine to surgery).

Challenges to the implementation of various teaching methods were outlined by the stakeholders. Some voiced concerns over the use of the word “mindfulness” which they expressed had become overused and could potentially be less effective in engaging Interns (similar to ‘Zoom fatigue’ and ‘survey fatigue’). Concerns were expressed regarding the practicality of establishing a longitudinal mentorship programme for the Intern year; the fragmented and short duration of the Internship was identified as a significant barrier. Lack of faculty training for trainers and senior trainees was identified as an additional barrier to mentoring, role modelling and to the development of guided reflective practice. Stakeholders discussed if mentors should be assessed and if mentoring should be voluntary or mandatory, with some suggesting that mentorship become part of higher training requirements. No consensus on these points was reached. The issue of “hierarchy” was raised in light of establishing an appropriate level for an assigned mentor to an Intern. Some stakeholders expressed the likelihood of an Intern feeling more ‘comfortable’ with a mentor that was not “*too senior*” to them (“*they are more likely to talk about, ...free relaxed speech, ...free opinions*”; “*and there isn’t this feeling that you can’t speak to someone who is only slightly above you ...whereas it is very difficult to engage if you are a nervous type of person ...with a Consultant*”). The converse was also discussed, a mentor “*too junior*” in training would potentially not be experienced enough. Issues were also raised around the potential conflict of a mentor becoming a potential assessor along an Intern’s future continuum of training. Other concerns revolved around conflicts that arise from the need to escalate concerns balanced against requests for confidentiality and discretion. Other barriers involved ensuring that appropriate processes are put in place for Interns who want to change mentors (or vice versa). Regarding quarterly self-reflection exercises, stakeholders suggested the use of online polling tools for large groups of Interns. This was an alternative to overcome both the lack of resources to support guided reflection with multiple small groups and could potentially overcome any reticence amongst the Interns in discussions. As one stakeholder stated:

*“Irish culture is not particularly open, and we are not very good at expressing emotions or feelings particularly in a public space, so we discussed making it virtual ...like kind of (an) online polling software to gauge where everyone is at. So, you would ask a group of people to relate how they were feeling from 1 to 10 on... ‘preparedness for practice’... ‘how do you identify as a professional?’ ...and then you would get a scale of responses and that may empower others to, ...express how they are feeling...”*

Stakeholders also highlighted significant concerns regarding written reflections, with some expressing that oral reflective practice was perhaps ‘safer’ than written logs from a medico-legal standpoint. Lack of dedicated time for faculty training and for the delivery of teaching, a lack of administrative, information technology, and infrastructure support were listed as additional significant barriers.

Stakeholders outlined alternative proposals for teaching ‘Be’ competencies. These suggestions were as follows: an intern retreat; simulation sessions; involvement of the team (as opposed to just the Intern); establishing a ‘buddy system’ (near-peer buddies); exploring the option of non-physicians assisting with self-reflective exercises (due limited time available for senior physicians to assist with reflective practice); establishing a form of “*quality assurance*” (to ensure the “*level and quality*” of Senior House Officer, Specialist Registrar and Consultant Trainer mentoring skills); and official recognition of near-peer or mentoring roles (in the context of mentoring as part of higher training requirements for Senior House Officers and Registrars). Stakeholders voiced how an official recognition of mentoring roles could potentially facilitate recruitment, retention, and positively influence institutional culture. Moreover, most stakeholders expressed how integration of mentoring and role modelling into the Intern year would improve levels of professionalism across all hospital medical staff.

Further study is needed within the Irish context to establish the feasibility and acceptability of selected teaching strategies.

### Assessment of professionalism and professional identity formation

The articulation of demonstrable ‘Be’ competencies helps make ‘professionalism’ explicit for Interns. Several ‘Be’ competencies are observable via EPAs such as: *participate in safe and effective handover procedures to ensure continuity of care; communicate in an open and effective manner with medical staff; document medications correctly*. These competencies lend themselves to assessment more readily via an EPA, in contrast to the implicit and more nuanced ‘Be’ competencies.

Stakeholders were asked to identify competencies of ‘being’ and ‘becoming’ a physician (competencies within the ‘Be’ component) that were not adequately addressed by

competency frameworks and EPAs alone. Many elements were identified by stakeholders including the following: *integrity and honesty, respect, insight and recognizing limits, humility, compassion, altruism, openness, reliability, cultural sensitivity, situational awareness, contentiousness, patient centeredness, self-care, reflective capacity*. There was stakeholder recognition that relying solely on demonstrable professional competencies and EPAs results in 'gaps' for the assessment of the more nuanced professional 'Be' competencies. This aligns with what has been noted in the literature, where many attributes associated with the role of a 'healer' are not well captured by EPAs (Swanwick, Forrest, & O'Brien, 2019).

### Stakeholder feedback on assessment

Multiple assessment tools for assessing professionalism and professional identity were presented by the international experts. These included Learning Logs and Portfolios, Identity Status Interviews, Professional Self-Identity Questionnaires, Professional Role Orientation Inventories, Professional Identity Essays. Other assessment strategies involve the Assessment of Clinical Teaching Tool, Longitudinal Professionalism Assessment Tool (L-PAT), Professionalism Mini-Evaluation Exercise, the use of Narratives, and Multi-Source Feedback (MSF) from medical students, support staff, trainers, peers, and patients.

The Assessment of Clinical Teaching Tool contains 15-items with a Likert scale for responses. The tool provides a means for trainees to assess Trainer engagement as teachers/role models. A sample of some of the questions in the tool are *Explained his/her reasoning; treated me with respect; modelled respectful interaction with other members of the healthcare team; provided me with opportunities to perform clinical activities/technical skills that fit my level of experience and competence; asked me to explain my reasoning; served as a role model for the type of doctor I would like to become*. This dual-purpose tool serves to both encourage and promote positive role-modelling amongst Trainers, and explicitly highlights desirable professional attributes for trainees.

Stakeholder feedback focused primarily on the Longitudinal Professionalism Assessment Tool (L-PAT) and on Multi-Source Feedback (MSF).

The Longitudinal Professionalism Assessment Tool (adapted by McGill University in Montreal, Canada) assesses in-training professional behaviour outside of clinical rotations with the aim of promoting professionalism. The attributes listed in the form are meant to align with an institution's Code of Conduct. Attributes assessed include *commitment, reliability, flexibility, responsiveness, punctuality, timeliness, collegiality, and communication*. Within the Irish context, the form would be completed six-monthly by the Intern Network Coordinator/Tutor who is informed by feedback from senior Registrars, the network administrator and other health-care professionals who interact with the Intern. The feedback is then reviewed in aggregate with the Intern during

scheduled assessments (formative and summative). The tool is intended for use primarily as an opportunity for discussion and learning with an Intern. A copy of the L-PAT from McGill University can be viewed in **Appendix M**.

Stakeholder feedback was highly receptive to the L-PAT. Initial issues revolved around ensuring confidentiality for individuals completing the tool. It was recognized that use of the tool in aggregate would obviate this concern. There were significant concerns raised in regard to the additional workload the L-PAT would place on network administrators; they would be required to complete 100 or more of these twice a year. Stakeholders determined that this was not a feasible option in light of limited resources and as an alternative, suggested that administrators complete the L-PAT to flag an Intern if there were particular administrative concerns. Stakeholders appreciated use of the tool in expediting the 'red-flagging' of Interns with 'professionalism' issues, and the broad spectrum from which the feedback was collected. It was generally felt this ancillary feedback would provide a more comprehensive view of an Intern's professional comportment. Issues of prejudice, bias and 'legal defensibility' were raised. The experts shared that the tool was not intended for high-stakes assessment but provided an opportunity for trainers to facilitate trainee insight around issues raised in the L-PAT.

Multi-Source Feedback involving feedback from medical students, support staff, trainers, peers, and patients was presented from both the North American and European expert experience. Stakeholders acknowledged the usefulness of 360-degree feedback however concerns were expressed. Issues primarily revolved around confidentiality and bias. The comparatively smaller Irish population introduced particularly unique challenges to using this form of assessment. Further discussions revealed concerns for MSF as an anonymous mechanism to deliver criticism rather than a useful tool to deliver feedback. Concerns were also raised with respect to Interns selecting the MSF evaluator, with questions raised about the validity of feedback that could be preferentially selected by Interns from favourable evaluators.

## Reflective Journal

The NDTP/MIB have identified the Reflective Journal as one of five workplace-based assessment tools for use within the new Intern curriculum (Offiah & Boland, 2020). Reflective practice supports the development of physician practices and skills and facilitates the transformation of professional identity. The benefits of reflective practice are long established in the literature (Mann, Gordon, & MacLeod, 2009). Reflection is identified as an essential element to 'Performance' in the Medical Council's *Three Pillars of Professionalism*.

Despite the potential benefits of reflective practices, trainer and trainee opinions reveal that reflective journaling without expert guidance often results in reflection without

learning, or “recipe following” as has been described in the literature (Boud, 1999). The international experts stressed guided reflective practice as critical to supporting Intern professional identity. A reflective journal may constitute an additional tool in the workplace-based assessment toolbox, however the benefits of engaging in the practice are not fully realised without a facilitator to guide deeper discussion furthering meaningful reflection. Amidst all other forms of assessments during the Internship year, without guided sessions, the reflective journal runs the risk of being a means to an end. The incorporation of journal entries into professional identity formation teaching sessions integrated within the Intern year can foster informed reflective practice so that it becomes a lifelong skill for all Interns.

### Personal and Professional Development Log

Competencies related to lifelong learning and continuous professional improvement were identified during the development stages of the EPAs. These competencies include the following: *role modelling, teaching, mentorship, advocacy, cultural sensitivity, feedback seeking behaviour, demonstrating initiative, motivation and foresight, awareness of limitations, ability to learn from mistakes, commitment to lifelong learning, promoting work life balance, stress management, recognition of bullying, reflective practice, performance of audits/research and associated processes (e.g., ethics applications)*. All these competencies were identified as relating to personal and professional development and as such, are listed within a ‘Personal and Professional Development Log’ (Byrne, et al., 2018). The Personal and Professional Development Log did not meet the criteria of an EPA but was recognized by the NDTP/MIB as including important competencies (Offiah & Boland, 2020) These competencies are all included within the ‘Be’ component of the new curriculum. The Personal and Professional Development Log was identified by the NDTP/MIB as a means of tracking the activities and achievements related to these competencies (Offiah & Boland, 2020). It is notable that the competencies above, that were deemed to fall outside the remit of an EPA, were amalgamated such that multiple important competencies are incorporated within a single 17-item checklist. There is huge merit in each of the competencies however, to meaningfully address them, dedicated guided reflection or longitudinal mentorship would be essential for this depth and breadth of input.

Despite the intrinsic benefits of the Personal and Professional Development Log and the Reflective Journal, both these assessment tools run the risk of becoming a *tick-box* exercise. This tick-box activity is further compounded by a lack of faculty training. Many trainers may fail to address items in the personal development log or reflective entries (with critical feedback necessary to supporting Intern reflection and development) due to a combination of time constraints and a lack of training in assessing reflective practice. To view the Personal and Professional Development Log see **Appendix N**.

## Project Limitations

It is recognized that the significant body of work required to date for the revision of the overall national Intern curriculum has been resource limited. The Curriculum Working Group for the revised Intern curriculum was small. Similar projects of this nature internationally, have involved multiple stakeholders over an extended period often years, with extensive input from both national and international experts. As an example, the Royal College of Physicians and Surgeons of Canada (RCPSC) convened a curriculum development process which commissioned a series of committees and thirteen expert working groups to revise aspects of their curriculum in 2013. In addition, twelve national medical education organisations took part in this work. A national advisory committee had expert working groups with senior stakeholders which saw the collaboration of “hundreds of dedicated medical educators, clinicians, learners, committee members and staff.” The overall process involved “countless hours of literature reviews, stakeholder surveys, focus groups, interviews, consultations, consensus-building exercises, debate, and work on educational design” (RCPSC, The CanMEDS 2015 project: methodology, 2022). In addition, the RCPSC noted that many international medical education organisations also contributed their expertise. They identified the process as a *herculean task* which extended from 2013 to 2015. While Ireland’s population is comparably smaller, its’ size should not undermine a rigorous approach to the overall process. A rigorous approach was undertaken to the dissemination and feedback on the ‘Be’ template in a manner aligned with the Canadian curriculum process within the severe resource constraints available.

Development funding provided financed the stakeholder engagement conference, delivery of international expert consultation, transcription costs for focus groups, interviews and discussion groups and dissemination costs. There was no funding provided for dedicated time for the project lead, other project stakeholders or project research facilitators who all provided their expertise and time on a voluntary basis. Future projects of such depth and breadth require dedicated funding for personnel (project lead and research support staff).

The project timeline was extended significantly by the unexpected Covid-19 pandemic. This led to unprecedented demands on Intern network educational staff who were required to develop and deliver new virtual training programmes and maintain teaching despite the requirement for Covid-19 related precautions. Network staff supported in emergency Covid-19 service response and facilitated teaching for increased Intern numbers. The National Stakeholder Conference was originally scheduled for September

2020. At this time there was a national lockdown and this conference had to be rescheduled to October 2021.

Curriculum material was not sent out to stakeholders prior to the conference. A decision was made to discuss the concepts of CBME, EPA, entrustment decisions, professional identity and to introduce the new curriculum framework in person prior to review of the curriculum to ensure a common baseline of knowledge and avoid duplication of work undertaken by stakeholders in preparation for the conference.

Regarding the development of the 'Be' component of the curriculum, the volume of material is significant and requires an iterative process of feedback and revision. Due to the limited time available from stakeholders, the intention of the two-day stakeholder conference was to present a draft 'Be' template and concepts to engage feedback to inform 'Be' component development.

This report is not intended to be a *comprehensive* and conclusive assessment of *stakeholder opinions, but rather a collective profile of the varied insights, perceptions, and feedback* from a diverse and extensive group of key stakeholders and international experts. The resulting consensus may serve to further inform current and long-term curriculum plans to ensure an operational integration of professional identity formation and 'professionalism' competencies of the 'Be' component within a competency-based curriculum.

## Recommendations

1. Recommend that professionalism holds equal focus with knowledge and clinical skills in the new Intern curriculum.

While many stakeholders viewed that a focus on professionalism was essential, some expressed concerns that many of the professionalism competencies were too advanced or aspirational; that the Intern year was primarily a ‘practical’ year. It is important that the focus not be a binary option. Professionalism competencies are inherent in *all* aspects of medical practice and should hold equal weight in the Intern curriculum. Ongoing work must be maintained by Medical Council to promote the importance of professionalism at every level of training.

*“But being a good doctor is more than technical competence”*

(Medical Council, Talking about good professional practice: Views on what it means to be a good doctor., 2014)

2. Recommend that the chosen framework for professionalism, the ‘Be’ template, underpins practice across the undergraduate to postgraduate continuum, including continued professional development and extending across all training bodies and universities.

The ‘Be’ template can serve as a standalone framework for professionalism. The ‘Be’ template domains and themes should remain uniform throughout the continuum of training and practice. Competencies should be targeted to a foundational or more advanced threshold as appropriate, across universities and training bodies. Intern training should not be viewed in isolation as it is the transition point between student and post graduate training.

3. Recommend that the Medical Council’s *Eight Domains of Good Professional Practice* serves as a comprehensive framework to underpin the ‘Be’ template.
4. Recommend that on translation of the Medical Council’s *Eight Domains of Good Professional Practice* into the ‘Be’ template, that revisions and updates are required.

Suggested revisions are necessary to reflect contemporary practice and the needs of patients and society.

5. Recommend that the Medical Council’s *Three Pillars of Professionalism* are not utilized as the framework for the ‘Be’ template. However, the content within the *Three Pillars of Professionalism* should be incorporated within the ‘Be’ template.

The definitions of the *Three Pillars of Professionalism* contained redundancy and were open to variable interpretation.

6. Patient safety is fundamental to delivering high quality patient services and should be incorporated into all three ('Know, Do, Be') components of the Intern curriculum to put a focus on reducing preventable harm to patients.

To ensure that patient safety is *expressly* highlighted for Interns, the development of a *Safety & Quality of Care* Module is recommended. This module should incorporate all elements of the patient safety domains. Aspects of patient safety that are rare and not routinely encountered but are high risk could then be addressed and assessed. This *Safety & Quality of Care* module could be delivered via a mix of the following: e-videos, interactive didactic sessions, and simulation sessions, covering topics such as open disclosure, reporting errors, prescribing, QI projects and audits, and would be mandatory for the Intern year. Similar to the mandatory requirement for Interns to complete BMJ modules, a mandatory *Safety & Quality of Care* Module could be submitted to a portfolio as body of assessment. A *Safety & Quality of Care* Module would be of benefit for several of the patient safety competencies which are currently listed in EPAs.

7. Recommend that *Communication* (a domain) and *Handover* (a theme) remain within the 'Be' template.

Some stakeholders identified that *Handover* was already incorporated as an EPA and suggested it be removed from the 'Be' template to minimize redundancy. A similar suggestion was made in relation to *Communication* which is incorporated within several EPAs. However, other stakeholders identified that themes and domains that are critical for patient safety would reasonably warrant inclusion across the 'Be' and the 'Do' components of the Intern curriculum. In general, redundancy should be minimized wherever possible.

8. Recommend the inclusion of '*Physician Well-Being and Self-Management*' as a domain.

This domain would replace and incorporate '*Physician Well-Being*' which is recognized as an essential determinant of optimal patient care. '*Well-being*' would encompass many aspects of self-care including burn out, work life balance, mental health in the context of challenging work-environments and managing expectations of the public. '*Self-management*' would incorporate other important elements of professionalism (such as punctuality, prioritisation, and time management, etc.). Of note, within the RACP framework, physician self-care is incorporated within the *Quality and Safety* domain and in CanMEDS it is incorporated within the domain of *Professional*.

9. Recommend inclusion of *Cultural Competency* within the 'Be' template.

There was consensus that *Cultural Competency* is required within the 'Be' template for the Intern curriculum, however there was lack of agreement on whether *Cultural Competency* should be included as a domain or theme. Feedback should be sought from a broader group of physicians and patients to provide a wider perspective. The stakeholder cohort was representative of the present population in medical leadership in Ireland. This population does not reflect the broader diverse population of physicians in clinical training and practice (which includes a large proportion of non-EEA and non-Irish trained physicians). Similarly, the stakeholders at the conference do not reflect the broader Irish population.

10. Competencies such as *Reflection, Role Modelling, Teaching, Mentorship, Leadership, and Life-Long Learning* need dedicated guidance for development at every stage of medical training including at the foundational Intern level.

Many stakeholders agreed that these competencies need foundational development at an *early* stage. These competencies should be included in the 'Be' template. It is notable that the RACP Professional Practice Framework includes *Role Modelling, Teaching, and Leadership* as individual domains.

11. Recommend inclusion of *Sustainable Health Care* as a theme under the domain for *Management* with the associated competency '*Demonstrates basic awareness of sustainability in medical practice and considers the impact of environmental issues on health*'.

The importance of *Sustainable Health* care involves the impact of health care resource utilization on the environment and the negative impact of environmental issues on patients and societal health.

12. Recommend that *Social Media* is maintained as an important theme.

There was a lack of consensus on the most appropriate location of *Social Media* within the 'Be' template. This warrants further discussion. Options would include incorporating *Social Media* into one of the following domains: *Communication, Physician Self-Management, Ethics and Professional Conduct*.

13. Stakeholders recommended using a spiral curriculum as the mechanism for progressing competencies across the transitions of training – from medical student to Intern, postgraduate training and beyond.

A spiral curriculum would support the 'Be' template as a standardised template across all levels of training and specialties. Allowing for a graduated development of competence.

14. Recommend delineating the specific 'Be' competencies to establish the threshold for 'readiness to practice' at transitions from undergraduate programmes to Internship, and beyond.

For competencies that were viewed as too 'advanced' by stakeholders, the competencies as outlined could be revised to reflect a more foundational level. In relation to the competency "*Use resources responsibly while considering the needs of the patients*". Excerpt of stakeholder feedback: "*sure you can't be asking Interns to do that*". This competency could be revised to: "*demonstrates an awareness of resource utilization while considering the needs of patients*". The Medical Council could guide the threshold for professional competencies, incorporating feedback from both patients and physicians.

15. Recommend the explicit integration of professional identity formation into the Intern curriculum.

This integration of professional identity formation will enable a clear articulation of professional competencies for Interns. Embedding professional identity formation within the Intern curriculum will require both teaching of professional identity formation concepts and a method of assessment. Establishing a cognitive base for professional identity formation and professionalism can be done via interactive large group teaching. Assessment might best be achieved by assessing the *engagement* with the process of professional identity formation via small/large group guided reflective sessions. Implementation of these strategies will depend on resource allocation including personnel, infrastructure, and training.

16. Recommend that professional identity formation be incorporated explicitly within the regulatory code of practice as outlined in the Medical Council's *Eight Domains of Good Professional Practice*.

The Medical Council has stated that "professionalism is a central part of being a doctor" and "our role is to define and promote professionalism" (Medical Council, Good professional practice, 2022). The recommendation above would mandate professional identity formation as a learning objective across universities and training bodies and reflect to the profession the importance of professional identity formation in physician professional development.

Two proposed pictorial representations of the Medical Council's *Eight Domains of Good Professional Practice* have been provided to demonstrate how professional

identity formation can be theoretically incorporated within the *Eight Domains* (see **Appendix O**). These were developed following review and feedback from the international expert group.

17. Recommend faculty development to facilitate, support and promote professional identity formation.

Faculty development supports a shared mental model and supports a change management process. Within the Irish context, a snowballing *train the trainer* approach may be the most accessible and practical means of training a broad range of clinician educators. This training should extend in the first instance to Intern Network Tutors, Coordinators and Training Leads.

18. Recommend assessment of Intern *engagement* with professional identity formation using quarterly reflective practice; assessment of professionalism with the Longitudinal Professional Assessment Tool (L-PAT) and Personal and Professional Development Logs.

Quarterly reflective practice could be incorporated at points of transition (at change of rotations) and at formative and summative assessments. Implementation of tools will depend on training, resource, and personnel availability.

Faculty development would support *guided* reflective practice and expert review of Personal and Professional Development Logs. Assessment tools such as reflective practice, reflective journals and Personal and Professional Development Logs risk becoming tick-box activities without guided discussion and feedback from trained trainers. A lack of trained faculty can increase failure to assess key professional competencies that inform entrustment decisions.

Of note, the teaching and assessment of professional identity formation will require further study in the Irish context.

19. Recommend patient and public involvement to provide a useful perspective to further refine the 'Be' template and content and ensure that the patient voice is central to its ongoing development.
20. Recommend that the current draft 'Be' template (**Appendix G**) is revised to incorporate recommendations from this report following on from feedback from stakeholder organisations involved in Intern training (Medical Council, NDTP, INE and universities).

The current draft 'Be' template was prepared to provide an initial draft on which to initiate conversation and engage stakeholders. This draft requires revisions and updates. International CBME curricula have committed to updating their

frameworks at regular interviews to ensure that they continuously meet the needs of patients and society. Likewise, the 'Be' template must be updated in an iterative manner into the future while be mindful of the capacity for stakeholder change.

21. Recommend revision of the draft 'Be' template with a detailed analysis and mapping between the 'Know' (knowledge) and 'Do' (workplace tasks) components takes place, to cross-check for redundancy.
22. Recommend socialisation of concepts and detail of the curriculum both in advance of and during curriculum roll-out.

This will require a major body of work with dedicated personnel.

23. Recommend that an online website with up-to-date content and tool kits is developed.

Online resources will provide information in an accessible format and align with other jurisdictions where competency based medical education has been implemented (AAMC, Core, 2022; ACGME, Milestone resources, 2022; RCPSC, Competence by design resource directory, 2022).

## Final comments

The Medical Council have mandated a transition to competency-based medical education which is a necessity to ensure patient safety, high-quality healthcare, and to best meet the needs of society. The Medical Council identifies professionalism as one of the *Eight Domains of Good Professional Practice* and this forms an excellent framework on which to base the 'Be' template for the new Intern curriculum. Professionalism is a core competency in competency frameworks internationally, (RACP, CanMEDs, ACGME, and others). It is well recognized in the literature that the teaching and assessment of professionalism is challenging. Integrating professional identity formation provides a means by which to address this 'gap' and facilitates the teaching and assessment of critical competencies for professionalism that evade EPAs. The integration of professional identity formation within the Internship year would enhance EPA guided entrustment decisions and foster a more holistic approach to Intern training.

The inherent value of competency-based medical education is clear, as medicine's social contract depends on more than just the assumption of competence. However, a sole focus on skills and knowledge without an equal focus on professionalism is not consistent with the expressed views of patients.

*Professionalism is a central part of being a doctor. Academic and clinical ability must be underpinned by professional attitudes and behaviour appropriate for doctors. Our role is to define and promote professionalism*

Irish Medical Council

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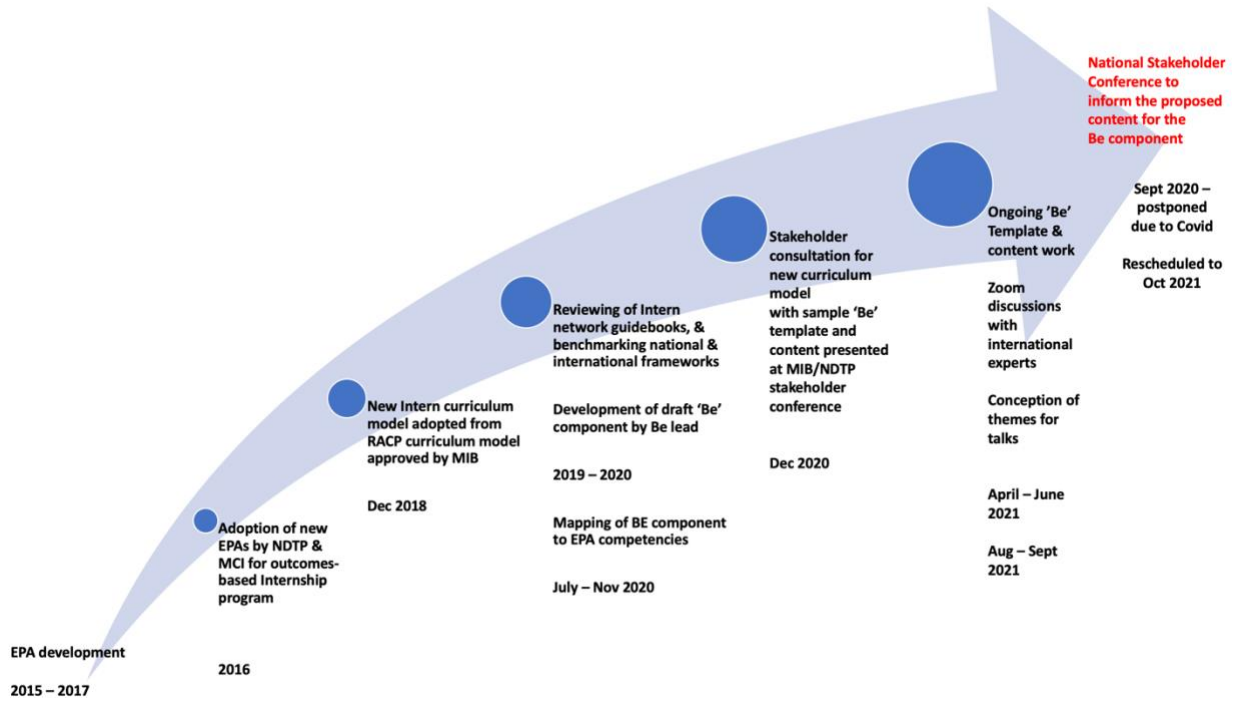
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# Appendices

## Appendix A: The timeline of the development of the Intern curriculum



Appendix B: Sample of Intern EPA (EPA 1: Admit patient)

EPA		No. 1		
<b>A.</b>	<b>Title</b>	<b>Admit a patient</b>		
<b>B.</b>	<b>Prerequisites</b>	Meet eligibility criteria for internship as determined by the Health Service Executive National Recruitment Service Basic Life Support (BLS) Certification Any other requirements as determined by the HSE NRS		
<b>C.</b>	<b>Description of the activity</b>	At the end of internship, the doctor should be capable of making a decision to admit and be able to admit a patient onto the ward (elective and emergency). The doctor should be able to communicate effectively with the patient and relatives and understand the patient's verbal and non-verbal communication. The admission should record a focused history, a thorough physical examination and a record of any pathological findings. This should form the basis for requesting laboratory and radiological investigations and consultations that are pertinent to the case, rationalised and reflect best practice. The admission note should be logically structured and the doctor should be able to prioritise diagnoses, interpret investigations and formulate a treatment plan.		
<b>D.</b>	<b>MC domains</b>	D2, D3, D7, P(i) & P(ii)		
<b>E.</b>	<b>Expected proficiency</b>	<b>Level 4</b> With the exception of competencies expected at another level (as indicated below)		
<b>F.</b>	<b>Competencies</b>	<b>Level</b>	<b>CP</b>	
1	Establish rapport with patient	4	X	
2	Consider factors that may affect the patient's capacity to describe their symptoms or understand questions and/or give informed consent	4	X	
3	Take a focused history in a range of contexts and conditions	4	X	
4	Obtain a history from other sources as required (e.g. collateral, own doctor, pharmacy)	4	X	
5	Know when and in what circumstances patient confidential information can and cannot be shared	4	X	
6	Perform a fluid and sequential clinical examination	4	X	
7	Demonstrate respect for the patient's privacy, dignity and culture	4	X	
8	Identify abnormal clinical findings	4	X	
9	Request laboratory and radiological investigations and consultations that are pertinent to the case and reflect best practice	4	X	
10	Act on conditions and presentations that require immediate intervention, instigate initial resuscitation/treatment and call for senior help	4	X	
11	Formulate a differential diagnosis	4	X	
12	Put a treatment and further management plan in place	3	X	
13	Consent a patient according to Medical Council guidelines	3		
14	Communicate transfer plan to healthcare receiver (ward, theatre, ICU), patient and relatives	4	X	
15	Document all findings in the patient chart to comply with medico-legal standards	4	X	
16	Follow prescribing protocols and discuss medications with senior colleagues	4	X	
17	Recognise patients at risk of deterioration	4	(TR)	
18	Communicate with senior colleagues and nursing staff to ensure all have a shared mental model of the patient's condition and needs	4	(TR)	
19	Communicate effectively with families and relatives of patients	4	(TR)	
<b>G.</b>	<b>Assessment tool/s</b>	<i>Case presentation (CP)</i>		
<b>H.</b>	<b>Basis for entrustment at level 4</b>			

Reproduced from Revised Framework of Outcomes for End of Internship in Ireland (Byrne & Boland, 2016)

## Appendix C: Timeline of development funding



## Appendix D: Medical Council's Eight Domains of Good Professional Practice

**Patient Safety and Quality of Patient Care:** Patient safety and quality of patient care should be at the core of the health service delivery that a doctor provides. A doctor needs to be accountable to their professional body, to the organisation in which they work, to the Medical Council and to their patients, thereby ensuring the patients whom they serve receive the best possible care.

**Relating to Patients:** Good medical practice is based on a relationship of trust between doctors and society and involves a partnership between patient and doctor that is based on mutual respect, confidentiality, honesty, responsibility and accountability.

**Communication and Interpersonal Skills:** Medical practitioners must demonstrate effective interpersonal communication skills. This enables the exchange of information, and allows for effective collaboration with patients, their families and also with clinical and non-clinical colleagues and the broader public.

**Collaboration and Teamwork:** Medical practitioners must co-operate with colleagues and work effectively with healthcare professionals from other disciplines and teams. He/she should ensure that there are clear lines of communication and systems of accountability in place among team members to protect patients.

**Management (including Self-Management):** A medical practitioner must understand how working in the healthcare system, delivering patient care and other professional and personal activities affect other healthcare professionals, the healthcare system and wider society as a whole.

**Scholarship Medical:** practitioners must systematically acquire, understand, and demonstrate the substantial body of knowledge that is at the forefront of the field of learning in their specialty, as part of a continuum of lifelong learning. They must also search for the best information and evidence to guide their professional practice.

**Professionalism:** Medical practitioners must demonstrate a commitment to fulfilling professional responsibilities by adhering to the standards specified in the Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners.

**Clinical Skills:** The maintenance of professional competence in the clinical skills domain is clearly specialty-specific, and standards should be set by the relevant postgraduate training body, according to international benchmarks.

## Appendix E: Medical Council's Three Pillars of Professionalism

Good professional practice is based on a shared understanding between the profession and public of the principles and values that underpin good care. These principles and values, and how they should be applied in practice, are set out in this guide, using the three pillars of professionalism – Partnership, Practice and Performance – as a framework. 4 Partnership – Good care depends on doctors working together with patients and colleagues toward shared aims and with mutual respect.

**Partnership:** Good care depends on doctors working together with patients and colleagues toward shared aims and with mutual respect.

**Practice:** This describes the behaviour and values that support good care. It relies on putting the interests and well-being of patients first.

**Performance:** This describes the behaviours and processes that provide the foundation for good care.

## Appendix F: Benchmarking frameworks

MCI 8 Domains of Good Professional Practice	RACP Professional Standards Framework								
	Medical Expertise: To serve the health of patients, carers, communities and populations								
	Quality & Safety	Communication	Health Policy & Systems Advocate	Leadership & Management & Teamwork	Judgement & Decision Making	Ethics & Professional Behaviour	Teaching & Learning	Research	Cultural Competency
Patient Safety Quality Of Care	XX								
Relating To Patients	X		X						X
Communication & Interpersonal Skills		XX							
Collaboration & Teamwork				XX					
Management (including Self-management)			X		X				
Scholarship							XX	XX	
Professionalism						XX			
Clinical Skills									

MCI 8 Domains of Good Professional Practice	CanMEDS					
	Medical Expert					
	Health advocate	Communicator	Collaborator	Professional	Manager	Scholar
Patient safety Quality of care	X					
Relating to patients	X					
Communication & interpersonal skills		XX				
Collaboration & teamwork			XX			
Management (including Self-management)					XX	
Scholarship						XX
Professionalism				XX		
Clinical skills						

Appendix F: Benchmarking frameworks (cont.)

MCI 8 Domains of Good Professional Practice	ACGME 6 Core Competencies					
	Quality Patient Care					
	Patient care	Interpersonal & communication skills	Professionalism	Systems-based practice	Practice-based learning	Medical Knowledge
Patient safety Quality of care	XX					
Relating to patients	XX					
Communication & interpersonal skills		XX				
Collaboration & teamwork		X				
Management (including Self-management)				X	X	
Scholarship					X	XX
Professionalism			XX			
Clinical skills	X					

Appendix G: Draft of proposed 'Be' template presented at the National Stakeholder Conference

**Proposed "Be" Template**

Draft template for the **BE** element of the framework  
with Pillars, Domains, Themes, Competencies  
(incorporating the MCI's 3 Pillars of Professionalism & an adaptation of the 8 Domains of Good Professional Practice)

**Pillars, Domains, Themes, Competencies**

Pillars	Domain	Theme	Competency
<b>PARTNERSHIP</b>	<b>PATIENT CENTERED CARE</b>	1.1 Patient centered approach	Adopt a holistic patient centered approach to care
		1.2 Compassion & Empathy	Demonstrate a caring attitude towards patients  Understand & address patients', families' and carers' physical and emotional health needs
		1.3 Trust & Respect	Establish a trusting & respectful partnership between doctor & patient; and between the medical profession and society
		1.4 Cultural Competency	Practice in an unbiased manner sensitive to context, gender, sexual orientation, racial, cultural, religious, and socioeconomic background in support of patient dignity
		1.5 Advocacy	Promote patient's preferences and autonomy as central to the provision of high-quality care  Advocate for fair use of resources for overall benefit of all patients
	<b>COMMUNICATION</b>	2.1 Communication skills	Use effective appropriate verbal, non-verbal and written communication skills at all times

<b>PARTNERSHIP</b>		2.2 Communication with patients, families and carers	Communicate effectively, collaboratively, and empathetically with patients and carers
		2.3 Communication with professionals and professional bodies	Communicate effectively and collaboratively with professional colleagues across disciplines and professional bodies
		2.4 Communication in challenging circumstances	Recognize that alternative styles of communication may be necessary in certain contexts
		2.5 Handover	Participate in safe and effective handover procedures to ensure continuity of care
		2.6 Social Media Conduct	<i>For further discussion</i>
		<b>COLLABORATION</b>	3.1 Collaboration
3.2 Inter-professional Teamwork	Ensure a combined action and cooperation towards a common goal of high quality patient care		
3.3 Accountability	Ensure that systems of accountability are in place among healthcare workers to protect patients		
3.4 Dignity in the Workplace	Recognize the right of all colleagues and staff to be treated with dignity and respect  Commit to ensuring a safe working environment; free from all forms of bullying and harassment		
<b>PRACTICE</b>	<b>PATIENT SAFETY QUALITY OF CARE</b>	4.1 Promoting Patient Safety	Take responsibility for the safe care of individual patients  Prioritise protection of children & vulnerable individuals
		4.2 Practice Management	Promote safe working practice & participate in quality improvement

<b>PRACTICE</b>		4.3 Prevention & Management of Risks & Potential Harm	Participate in recognition of and reporting on adverse events and errors to improve healthcare systems
		4.4 Confidentiality	Maintain confidentiality in all aspects of patient care
		4.5 Documentation & Information Management	Comply with organizational policies for timely and accurate documentation in accordance with legal requirements and IMC guidance
		4.6 Open disclosure	Practice in accordance with HSE policy for open disclosure
		4.7 Complaints	Respond appropriately to patient complaints
		4.8 Human Factors	Recognize role of human factors in medical errors and takes steps to minimize these
	<b>MANAGEMENT</b>	5.1 Management	Manage ward, clinic, and on call duties with prioritisation or delegation of clinical tasks efficiently & effectively
		5.2 Resource Use	Use resources responsibly while considering the needs of patients
	<b>ETHICS &amp; PROFESSIONAL CONDUCT</b>	6.1 Medical Ethics & the Law	Practice in accordance with current community and professional ethical standards and legal requirements
		6.2 Honesty & Integrity	Be aware of personal beliefs and attitudes and reflect critically on how these can affect patient care <hr/> Conduct oneself with honesty, report accurately, refrain from plagiarizing, and acknowledge personal errors <hr/> Recognize, openly state or address conflict of interest
		6.3 Responsibility & Participation	Recognize and respect personal and professional integrity, roles, and contribution of peers <hr/> Practice within one's limits and within ethical and professional frameworks, seeking help as required

<b>PERFORMANCE</b>	<b>MEDICAL EXPERTISE</b>	7.1 Acute Management	Recognize acutely unwell patients, initiates management and escalates as appropriate
		7.2 Synthesis	Gather all relevant data (e.g. clinical context, age and/or presence of comorbidities) to inform the development of a differential diagnosis
		7.3 Clinical Management Plan	Formulate management plan in partnership with patients and families/carers; in collaboration with the multidisciplinary health care team, applying a patient centered and integrated care approach
		7.4 Broader factors	Identify individual, social and cultural factors and the impact of these on diagnosis and management
	<b>SCHOLARSHIP</b>	8.1 Reflection	Engage in an audit and has an awareness of scope of practice
			Reflect critically on all challenging interactions, and on any personal shortcomings with a constructive approach to personal development
		8.2 Role modelling	Display personal comportment and behaviour consistent with the values outlined in the IMC Guide to Professional Conduct & Ethics; with reference to both the formal and informal ('hidden') curriculum
		8.3 Teaching	Use appropriate resources and educational best practice to promote understanding of health and disease amongst patients, colleagues, other healthcare professionals and medical students
		8.4 Mentorship	Facilitate the professional development of students and peers in a safe and supportive environment
		8.4 Leadership	Demonstrate the ability to lead in clinical practice
		8.5 Life-long learning	Refer to evidence-based clinical guidelines, commit to continuous professional development, and acquire an understanding of research
	<b>PHYSICIAN WELL-BEING</b>	9.1 Health & Well-being	Maintain personal health and wellbeing and consider the health and safety of peers, junior and senior colleagues and other health professionals

## Appendix H: Workplace-based assessment tools

<p><b>Case Presentation (CP)</b></p> <p>A Case Presentation is a formal communication between health care professionals. An Intern presents a patient's case to a supervisor and/or another member of the clinical team. A Case Presentation usually takes place alongside routine clinical care on a ward round, or an outpatient or General Practice setting. It assesses a trainee's ability to communicate, gather data (including from a physical examination), provide a differential diagnosis and present a management plan. The supervisor hears the presentation, probes for clarification, and provides feedback.</p>
<p><b>Direct Observation of Procedural skills (DOPS)</b></p> <ul style="list-style-type: none"><li>I. Clinical tasks</li><li>II. Procedural skills</li></ul> <p>A Direct Observation is a tool used for observing an Intern's performance of a clinical task (e.g., taking a history or receiving a handover) or a procedure (e.g., inserting a urinary catheter). Direct observations take place as a routine part of clinical work with patients or in a simulated environment. The observation is carried out by a health professional who provides feedback.</p>
<p><b>Case Based Discussion</b></p> <p>A Case Based Discussion is a discussion between a health professional and an Intern about a selected patient case. A CBD can assess an intern's application of knowledge, their clinical reasoning, decision making, problem solving, patient management skills, leadership skills and time management skills. A CBD is carried out by a supervisor or other health professional who acts as the reviewer and provides feedback.</p>
<p><b>Reflective Journal</b></p> <p>A reflective Journal provides the intern with an opportunity to provide evidence of their learning and insight. With regular and contemporaneous journal entries the intern describes and analyses an event and records their reflection and insights on aspects of their own practice.</p>
<p><b>Team Review</b></p> <p>Team Review is a multi-source method of assessment, including self- assessment, in which Interns are provided with feedback on their observed performance, including professional behaviour (e.g., by doctors, nurses, peers, patients and administrators) and where they reflect on their own learning and progress</p>

Definitions adopted from NDTP/MIB A National Curriculum for the Internship programme Consultation Document (Offiah & Boland, 2020)

## Appendix I: International expert speaker biographies

**Richard L. Cruess** graduated with a Bachelor of Arts from Princeton in 1951 and an MD from Columbia University in 1955. Having completed residency training in orthopaedic surgery at the Royal Victoria Hospital and Columbia University, he joined the Faculty of Medicine at McGill University and has spent his entire professional career in that institution. He is Emeritus Professor of Surgery and of the McGill Institute for Health Sciences Education. An orthopaedic surgeon, he served as Chair of Orthopaedics (1976-1981), directing a basic science laboratory, and publishing extensively in the field. He was Dean of the Faculty of Medicine from 1981 to 1995. He was President of the Canadian Orthopaedic Association (1977-1978), the American Orthopaedic Research Society (1975-1976), and the Association of Canadian Medical Colleges (1992-1994). He is the recipient of an honorary degree from Laval University. He is a Companion of the Order of Canada and an Officer of l'Ordre National du Québec. Since 1995, with his wife Dr. Sylvia Cruess, he has taught and carried out independent research on professionalism in medicine. They have published widely on the subject and been invited speakers at universities, hospitals, and professional organizations throughout the world. Together they have received the Ian Hart Award from the Canadian Association of Medical Education, the Gold Medal of the Association for the Study of Medical Education (ASME) in the United Kingdom, and the Flexner Award from the Association of American Medical Colleges. In 2010 McGill University established the Richard and Sylvia Cruess Chair in Medical Education and in 2018 the McGill University Health Centre named its principal amphitheatre in their honour.

**Sylvia R. Cruess** graduated from Vassar College with a Bachelor of Arts in 1951 and an MD from Columbia University in 1955. She is an Endocrinologist, Professor Emerita of Medicine, and of the Institute for Health Sciences Education at McGill University. She previously served as Director of the Metabolic Day Centre (1968-1978) and as Medical Director of the Royal Victoria Hospital (1978-1995) in Montreal. She was a Member of the Deschamps Commission on Conduct of Research on Humans in Establishments. Since 1995, with her husband, Dr. Richard Cruess, she has taught and carried out research on professionalism in medicine. They have published extensively on the subject and been invited speakers at universities, hospitals, and professional organizations throughout the world. Together they have received the Ian Hart Award from the Canadian Association of Medical Education, the Gold Medal of the Association for the Study of Medical Education (ASME), and the Flexner Award from the Association of American Medical Colleges. She is an Officer of the Order of Canada. In 2011 McGill University established the Richard and Sylvia Cruess Chair in Medical Education and in 2018 the McGill University Health Centre named its principal amphitheatre in their honour.

### **Stan Hamstra**

Stan Hamstra recently returned to the University of Toronto from the Accreditation Council for Graduate Medical Education in the USA. He also holds an adjunct appointment at Northwestern University's Feinberg School of Medicine in Chicago. Dr. Hamstra's primary research focus is on correlating surgical performance and training to patient outcomes. While at the ACGME, Dr.

Hamstra was responsible for research on the ACGME Milestones for resident physician progression and board eligibility. Dr. Hamstra works with various medical specialty societies, programme director organizations, and specialty certification boards. His research addresses medical education broadly, including competency assessment for residency training programmes, and developing administrative support for educational scholarship within academic health settings. Dr. Hamstra has also had faculty positions at the University of Michigan, and the University of Ottawa. He continues to work closely with the Royal College of Physicians and Surgeons of Canada on developing policies regarding competency-based medical education for graduate medical education.

**Robert Sternszus**, MDCM, MA (Ed), FRCPC, is a Hospitalist Paediatrician and an Assistant Professor of Paediatrics and Health Sciences Education at McGill University. He also completed a Master's degree in educational and Counselling Psychology (Health Professions Stream) at McGill University in 2015. Dr. Sternszus has extensive involvement in graduate medical education in Canada having served as the Director of the Paediatrics Residency Training Programme at McGill University from 2017-2021 and currently serving as a member of the National Residency Accreditation Committee of the Royal College of Physicians and Surgeons of Canada. Dr. Sternszus is also the Co-Director of the Foundations in Medical and Health Sciences Education Elective at the Institute of Health Sciences Education. He is involved in the teaching of professionalism and communication skills as well as in researching resident role modelling, professional identity formation, medical student curiosity and the role of residents as teacher.

#### **Olle Ten Cate**

Olle ten Cate, PhD is a professor of medical education at University Medical Centre Utrecht, the Netherlands, and adjunct professor of medicine at the University of California, San Francisco. With a background of undergraduate medical training and a PhD in social sciences, he has four decades of experience, at the Universities of Amsterdam and Utrecht, with curriculum innovation, educational research, and faculty development in the health professions domain, locally, nationally, and internationally. He was the founding director of the Centre for Research and Development of Education at UMC Utrecht (2005-2017), served as the president of the Netherlands Association for Medical Education (2006-2012), and has published (450+) and presented (500+) widely about advances in health professions education. He has successfully mentored 24 doctoral students for a PhD in health professions education and currently supervises 9 candidates. For his work he received several awards, among which the J.P. Hubbard award of the National Board of Medical Examiners, the Ian R. Hart award for innovation in medical education, the NVMO Han Moll medal and a Dutch Royal Distinction for contributions to medical education.

One of his interests is competency-based education in the health professions, and specifically in the application of entrustable professional activities and entrustment decision making, to improve education to serve the quality and safety of health care practice.

## Appendix J: List of stakeholders engaged

STAKEHOLDER NAME	ORGANIZATION/ROLE
Dr. Anne Merrigan	Co-Coordinator MWIN, UL; RCPI
Prof. Frank Murray	Prior President RCPI & Clinical Lead NDTP
Mr. Leo Kearns	CEO Medical Council Ireland
Prof. Tom O'Dowd	Past Chairman of the Education Committee of the Medical Council; Professor & Chair of General Practice
Prof. Ed McKone	Director of Education and Training, Institute of Medicine Board, RCPI, Respiratory Physician SVUH, UCD
Dr. Brian Kinirons	NDTP Lead; Consultant Anaesthesiology, Galway
Prof. Derek Gallen	National Academic Track Lead, UK
Prof. Martina Hennessy	Wellcome HRB-Clinical Research Facility, St. James's Hospital
Prof. John Jenkins	MIB Chair
*Prof. Mike Watts	Associate National Director of Higher Specialist Training; RCPI
Prof. Michael Gill	Dean Trinity College Dublin (Professor of Psychiatry & Head of Discipline)
Mr. William Kennedy	Director of Regulation Department; Solicitor, Medical Council Ireland
Dr. Brian McEllistrem	ICGP Curriculum Development Fellow
Dr. Eva Doherty	Director of Human Factors in Patient Safety; RCPI; National Representative and Co-Chair Intl. Assoc. for Communication in Healthcare; Clinical Psychologist
Dr. Michael Griffin	Director of Mid-West Specialist Training Scheme in General Practice; Consultant Trainer General Practice
Dr. Karena Hanley	ICGP General Practice Training & Innovation & Development Lead
Dr. Joshua Skeens	NCHD SHO Trinity College Dublin / Academic Track (recent Intern)
Dr. Elaine Burke	Tutor TCD/DSE Network; PhD (candidate)
Prof. Margaret O'Connor	Co-Coordinator MWIN, UL
Prof. Paula O'Leary	Dean of Medicine, UCC; prior Chair of INE
Prof Deirdre McGrath	Dean UL HoS
Mr. Paul Burke	Chief Academic Officer, ULHG, Mid-West
Dr. Orla Burke	Pediatrics lecturer, UL
Dr. Helena McKeague	BMBS Course Director, UL
Dr. Elyassa Hamza	BST SHO pediatrics Galway (recent Intern)
Dr. Sarah O'Connell	Associate Clinical Director; Consultant Trainer, ULHG
Dr. Rachel McNamara	NDTP Spark Lead
Mr. Evan Blake	TCD/DSE Network; INE Administrator Representative
* Prof. Paul Finucane	Past Dean of Medicine, UL; past member of Irish Medical Council
Dr. Ahmed Gabr	SpR Medicine & Masters in Clinical Medical Education; PhD (candidate)
Dr. Paul O'Hara	Training Lead; Med Ed; Ballinasloe Hospital & Saolta Hospital Group
Dr. Aoife Leahy	Lead NCHD, SpR, PhD (candidate)
Dr. Basil Matti	SpR Psychiatry; Psychiatry Mental Health
Prof. Rose Galvin	Professor of Physiotherapy, UL; HRB Research Leader Awardee
* Dr. John McManus	NDTP Training Lead, Mid-West
* Dr. Diarmuid Hilton	Consultant Trainer, Acute Medicine
* Dr. Colin Quin	Consultant Trainer, Geriatrician
* Dr. Majed Henin	Consultant Trainer, General Medicine
* Dr. Catherine Peters	Clinical Director; Consultant Trainer - General Medicine
* Dr. Elaine Shanahan	Consultant Trainer, UHLG
Dr. Aileen Paterson	Curriculum Advisor/Asst Prof. Medical Ed, Surgery, TCD
Dr. Caroline Herron	National Lead NCHD/NDTP Fellow 2021-2022 / SpR Gen Surgery
Ms Louise Barry	Qualitative Researcher
Ms. Sheila Carew	Advanced Nurse Practitioner; MSc
Ms Colette Devlin	Research Nurse, Health Research Institute, UL
Ms Gillian Corey	Research Nurse, Health Research Institute, UL
Ms Ida Carroll	Advanced Nurse Practitioner; Qualitative Researcher
Ms. Nora Cunningham	Advanced Nurse Practitioner, PhD (candidate)
Dr. Orla Mongan	GP; Tutor West North West Intern Network; Lecturer in Intern Education, NUIG
Dr. Gozie Offiah	Clinical Lead MIU/NDTP; RCPI
Dr. Josephine Boland	External Educational Consultant
Dr. Natasha Slattery	MEHP Fellow; Clinical Educator, MWIN, UL

\* Denotes stakeholders who attended pre-conference 60 - 90 minute interviews / focus groups.

## Appendix K: Outline of conference talks and sample interview/discussion questions

### Talks & Workshops delivered:

- *'Introduction to key concepts'*
- *'Overview of proposed template and content for a national 'Professionalism' curriculum for the Intern year'*
- Frameworks for professionalism in Ireland and the Medical Council's definition of professionalism. Feedback and consensus on template for 'Be' pillar.
- Alternative strategies for teaching & assessing professional identity formation to align with competency-based curricula.
- Establishing ideas for the Irish context.
- *'Professional identity formation and competency-based postgraduate medical education.'*
- *'Working with and beyond EPAs: Strategies for integrating professional identify formation into graduate medical education.'*
- *'Professionalism is not an EPA but how do they relate?'*
- *'EPAs in the US context – lessons learned'*

### Sample Questions:

1. Domains & Competencies: would you add or remove any domains and/or associated competencies? Please clearly document on sheet.
2. Refer to document: 'New domains for consideration'. What new domains might be particularly important within the Irish context?

#### New Domains for Consideration

##### Health policy and systems

- Decision making / diagnostic reasoning
  - Teaching (this is currently under scholarship. Should it be its own domain?)
  - Research (this is currently under scholarship. Should it be its own domain?)
  - Cultural competence
  - Integrated care
  - Pandemic/emergency response
3. Look at the competencies. Which of the 'Be' competencies are a 'Do', which are a 'Know' and which are identified as being a 'GAP'. Circle Gaps.

## Appendix K: Outline of talks and sample focus group discussion questions (cont.)

4. Are the 9 domains 'homed' under the appropriate Medical Council Professionalism Pillar? (Partnership, Practice, Performance). If not – indicate where you would place them.
  
5. Are the definitions of the Medical Council's *3 Pillars of Professionalism* clear or ambiguous? – explain and state why (refer to pack materials for diagram of Medical Council's *3 Pillars of Professionalism*)
  
6. What key elements of your ideal 'Be' curriculum are not easily captured by competencies and/or EPAs?
  
7. Pick 1 or 2 of the presented ideas for integrating professional identity formation (or chose one of your own)
  
8. Discuss how it/they could be implemented in your curriculum
  - What are the facilitators and barriers?
  - What would still need to be figured out?
  - What infrastructure would be needed?
  - What adaptations may be needed?

## Appendix L: Excerpts of stakeholder perceptions

### Stakeholder views on Professionalism and Professional identity formation

*It's kind of funny though because it's (the) small behavioural things that starts when you start working.*

*Compassion is a 'Do' because you don't actually need to have to have compassion to demonstrate a caring attitude.*

*...(you) can only teach people what it should look like... And then it is up to them to feel it. If they can fake it until the make it, there is no issue with that is there?*

*The person, if you are a horrible, horrible, person, who have no time for patients whatsoever. But if you walk into the room and demonstrate you will treat patients, and you've managed to convince the patient that you respect them, then you haven't developed professional identity....You don't have integrity. So, we can never assess that. I think you can only assess what we see. And if you are faking it, then that is good enough, isn't it?*

*I think you can teach professionalism. And you can tell them what professional identity formation is... But I think it is up to the person to fill in the gaps and to get professional identity.*

*You know in terms of what you know do you know aspire to be the kind of person who always responds to patient's complaints.*

*...depending on your personality and how you are, you might respond differently to complaints...*

*(If) it was 2 o'clock in the morning when you are not being firmly assessed... By 'being' it, you are going to have to 'do' it*

*I think that the NDTP and Medical Council has to decide about the curriculum, about whether or not it's just about identifying the competencies to be achieved, whether they're in the 'Be' part, the 'Know' part or the 'Do' part, but also the extent of which the Medical Council is responsible for the quality of the internship, provides any direction or regulation around process, around what kind of processes need to be in place, because things like professional identity formation are not going to be achieved by writing a curriculum, state the document. They're only going to be achieved if you train people to do all this stuff, if you resource people to do all this stuff, and if, if it becomes part of the curriculum. And what I mean by the curriculum, not just the competencies that have to be achieved, but the processes that have to be put in place.*

## Appendix L: Excerpts of stakeholder perceptions (cont.)

### **Stakeholder views on Competencies and Assessment:**

*It's important but at the same time more knowledgeable. I suppose we need to inspire what's the right thing to do.*

*Absolutely oh yes absolutely.*

*'Be' competencies are, should not limited to interns – they should be developed more evenly with doctors and then different levels... it shouldn't be unique to the intern year.*

*There is not much where we are being taught how to teach, or how to support. I'm not sure how ...how honest we are into putting it into, this is what we do, if we don't really do it. There's a lot of stuff that I think we don't actually ...manage to do.*

*No point in having a world class curriculum unless it can be implemented and delivered.*

*People are afraid you know to be honest about things because the country is too small, and everybody knows it is a real barrier to self-reflective practice.*

*Reflective journals – not a fan but I did like his scale - it was very simple, you just marked where you were on the scale and you gave what might help you change, or if you've moved up or down and discuss why that happened.*

*It was also not, you know, pages and pages of I did this and I did that today ...it wasn't just writing in a journal, it was actually a facilitator process."*

*If we don't build it they won't come.*

*...there was the inclusion of a couple of other tools, other than direct observation and case based discussion, but also reflective journal and team review...*

*...these provide really interesting opportunities for capturing the kind of data around self-reflective practice, but also around how others view the professional, and it would be really interesting to see what people think about how feasible it is, in the context of internship, how things like a reflective journal, combined with these kind of teaching and learning strategies might be used as an assessment tool, and how something like a team review might be used, akin to what he was talking about, and getting other peoples' views on the actual integrity and humility and professionalism of an intern. So I'd be really interested to hear how people feel those kind of tools might be...feasible within the context of an internship. But I really like the emphasis on process, and whether or not in a curriculum, the curriculum should also attend to - these are the*

## Appendix L: Excerpts of stakeholder perceptions (cont.)

*kind of teaching and learning strategies that need to be included for an internship programme, if you want to have a universal, national curriculum.*

*I think at the end of the day you want a competent caring doctor who puts patients first and works better as a member of a team. I'm a little bit concerned...*

*I think that there is a danger of having a vast amount of stuff that becomes a tick box exercise, that people often feel they need to prepare for, and it distracts them from becoming competent doctors, they have to stand up on their own in the ED as an SHO the following year.*

*Yes, I'm with you on this one... If you go too far with the detail and it becomes that, and what you will do as a Consultant, you know your Intern, you'll think this is a pretty good, this is a good Intern and you will backfill all of the other things because it is easier to (do) that rather than actually assess each one. So, it's a bit like a builder when he wants to... he will give you a price overall for the house and then he will backfill it into the foundations, the walls, the doors, and everything else. But he doesn't actually work from the bottom up, he works from the top down.*

*I think when he is an SHO in ED 12 months later, if he doesn't know what they all mean, all of this here, is actually counter-productive, it's going to kill patients. If he doesn't know how to interpret the important vital signs. Do you see what I am getting at? I am just a bit concerned...*

*Yes. Looking at the skills rather than...*

*I am a bit concerned about where the priorities end up, if we put something like this in place and it becomes... the Internship is about tick boxing all of this, as opposed to either transitioning from being a student to being an independent practitioner as you are.*

*I am going to say quickly, I'd rather he was good at putting in IVs and interpreting blood gases and knowing the importance of a high lactate than advocating for resources for all patients.*

*I think to be fair through this is just one theme of three.*

*Yes I suppose this is the profession... .... discussing about professionalism.*

*So there is a 'Know' and a 'Do'.*

Appendix M: Longitudinal Professionalism Assessment Tool (L-PAT)

**McGill Pediatrics Residency Training Program  
Longitudinal Professionalism Assessment Tool (LPAT)**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

This form is intended to promote professionalism by assessing in-training professional behaviour which occurs outside of the context of clinical rotations and does not lend itself to documentation in the usual clinical rotation evaluation form. The attributes described below are meant to be in compliance with the Code of Conduct of the Faculty of Medicine.

This form should be completed every 6 months by the Program Director based upon collated feedback from the Chief Resident, Program Administrator, and other health-care professionals interacting with residents and should be reviewed with the resident at the scheduled 6 month reviews with the Program Director. These forms will remain in each resident's academic file, and be used for promotions as per McGill's Evaluation and Promotion Guidelines.

**The resident demonstrates the following attributes of professionalism:**

**Commitment and Reliability:**

Takes share of responsibility for on call and other clinical duties as defined by the Pediatrics Residency Program  
Participates fully as a team member and avoids individualistic attitudes and behaviours

	Could Not Judge	1 Unsatisfactory Rarely meets expectations	2 Borderline Inconsistently meets expectations	3 Satisfactory Consistently meets expectations	4 Satisfactory Sometimes exceeds expectations	5 Superior Consistently exceeds expectations

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Flexibility and Responsiveness:**

Willing to step in when colleagues fall ill  
Participates in problem solving when unexpected issues or problems of coverage arise

	Could Not Judge	1 Unsatisfactory Rarely meets expectations	2 Borderline Inconsistently meets expectations	3 Satisfactory Consistently meets expectations	4 Satisfactory Sometimes exceeds expectations	5 Superior Consistently exceeds expectations

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Punctuality and Timeliness:**

Submits scheduling and call requests well in advance and in reasonable number  
 Shows up on time for clinical, academic activities and meetings  
 Responds to pages and e-mails in a timely fashion  
 Provides appropriate notification of absences

	Could Not Judge	1 Unsatisfactory Rarely meets expectations	2 Borderline Inconsistently meets expectations	3 Satisfactory Consistently meets expectations	4 Satisfactory Sometimes exceeds expectations	5 Superior Consistently exceeds expectations

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Collegiality and communication:**

Behaves in a respectful and collegial manner with staff, allied health professionals, support staff and colleagues  
 Demonstrates appropriate and effective oral and written communication  
 Prevents or solves conflicts effectively

	Could Not Judge	1 Unsatisfactory Rarely meets expectations	2 Borderline Inconsistently meets expectations	3 Satisfactory Consistently meets expectations	4 Satisfactory Sometimes exceeds expectations	5 Superior Consistently exceeds expectations

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Appendix M: Longitudinal Professionalism Assessment Tool (L-PAT) (cont.)

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**The following will be displayed on forms where feedback is enabled...**  
*(for the evaluator to answer...)*

\*Did you have an opportunity to meet with this trainee to discuss their performance?

- Yes
- No

*(for the evaluatee to answer...)*

\*Did you have the opportunity to discuss your performance with your preceptor/supervisor?

- Yes
- No

\*Were your clinical skills observed?

- Yes
- No

\*Are you in agreement with the assessment?

- Yes
- No

Please enter any comments you have (if any) on this evaluation.

## Appendix N: Personal and Professional Development Log

### Engage in personal and professional development – not an EPA

A further requirement for successful completion of Internship (Not an EPA)		
A.	Title	Engage in personal and professional development
B.	Prerequisites	Meet eligibility criteria for internship as determined by the Health Service Executive, National Recruitment Service & Medical Council Basic Life Support (BLS) Certification
C.	Description of the activity	At the end of internship, the doctor has achieved all EPAs to a level 4, and be a well-rounded professional who strives to improve themselves clinically and educationally. They are aware of their limitations. They are capable of learning from mistakes and recognise the learning opportunities that come from feedback. They actively seek out learning and feedback opportunities. They have the foresight, motivation and initiative to focus on achieving longer term training opportunities and goals. They support and participate in health promotion, audit and research. They advocate for patients and strive to maintain patient trust in themselves and the medical profession. They act as role models for other doctors, healthcare professionals and medical students.
D.	MC domains/pillars	D1, D6, P(ii) & P(iii)
E.	Expected proficiency	Level (i.e. the intern may perform an activity independently with distant supervision)
F.	Competencies	
1	Participate in research – basic original research, case reports etc.	
2	Participate in a clinical audit	
3	Participate in research processes – ethical approval, biostatistics, writing of abstracts and papers	
4	Prepare for and present at journal club meetings, grand rounds and national meetings. Look for opportunities to present at international meetings	
5	Complete and record all education and training requirements (maintaining a logbook or e-portfolio) within the required timeframe and seek out opportunities to fulfil learning targets	
6	Attend on time for clinical and educational activities – demonstrate good time management	
7	Engage with undergraduate teaching programmes such as near peer programmes	
8	Act as mentors and role models to undergraduate students and junior learners	
9	Attend interviews well prepared, with a well-constructed up to date curriculum vitae	
10	Engage with self-directed learning – online learning, training days and courses	
11	Practice in accordance with the Medical Council's guide to professional conduct and ethics (three pillars of professionalism)	
12	Promote patient safety and make it a priority in clinical practice	
13	Shows evidence of reflection on a patient safety issue with thought about possible causes, including role of human factors and system error	
14	Aim to achieve and promote a good work-life balance	
15	Manage stress and burnout and recognise it in colleagues	
16	Recognise bullying/demeaning behaviours in self/other colleagues	

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## Appendix N: Personal and Professional Development Log (cont.)

17	Be sensitive to and respect different cultures in the healthcare workforce	
18	Update the Curriculum Vitae regularly	
19	Keep up to date with developments in their field of practice and with clinical guidelines and pathways	
20	Be familiar with patient safety checklists and pre theatre checks (WHO safe surgery check list)	
21	Respect and comply with healthcare institutions' policies on health screening and immunisation, data protection and social media	
22	Demonstrate truthfulness and trustworthiness in communication with patient and colleagues in professional work and research	
<b>G.</b>	<b>Observation and Review tool/s</b>	<b>Personal and Professional Development Log (PPDL)</b>
<b>H.</b>	<b>Basis for completion</b>	<i>To be confirmed</i>

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Appendix O: Two proposed pictorial representations for re-imagining the *Eight Domains of Good Professional Practice* with the integration of professional identity formation



Appendix O: Proposed pictorial representations for re-imagining the *Eight Domains of Good Professional Practice* with the integration of professional identity formation (cont.)



Images above are representative of proposed pictorials. Final versions will require professional graphic design input.

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