Role Models: Just What the Resident Ordered?
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Summary
In postgraduate medical training, role models help our trainees as they work toward becoming competent practitioners. Along the way, however, trainees also desire these same role models to guide their career decisions as they transition into independent practice.

Résumé
Au cours de la formation médicale postdoctorale, les modèles de rôle inspirent les médecins résidents dans l’acquisition et le perfectionnement de compétences professionnelles. Et les médecins résidents espèrent que ces modèles de rôle les guideront dans leurs décisions de carrière au moment où ils amorceront leur pratique indépendante.

I recently attended the International Resident Leadership Summit (IRLS), run in parallel with the International Conference on Residency Education, in Calgary, Alberta. The IRLS was attended by trainees from around the world, representing many different disciplines. The focus of these sessions was mainly on the development of personal leadership skills. Participants were able to share insights in small workshop groups. One theme in particular stood out to me: time and again, trainees voiced their desire, and in fact their need, for strong role modelling throughout the various phases of training. I found it interesting that this group of self-selected leaders had such an inclination to be led. After all, do we not tend to think of leaders as visionaries and independent trailblazers?

Upon further reflection, I suppose this is not all that surprising. If one thinks of any successful leader, whether it be in medicine, politics, education, etc., there is generally a background story of an influential role model or mentor along the way. Most autobiographies that I have read of successful people outline this in detail. If we think of the very beginnings of the art of medicine, some 2,400 years ago in Ancient Greece, we find education by apprenticeship. Long before the advent of formal medical curricula, the only way one could learn the art was to align oneself with a role model. This role model would teach not only content knowledge, but also the “non–Medical Expert” expectations, as we know them today.

In the modern era of Western medicine, the volume of scientific knowledge far exceeds any single practitioner’s capacity to absorb it, let alone retain or apply it. In the past century, there has been an explosion in knowledge, allowing us to implement evidence-based best practices. As a result, the health of the developed world has improved to a remarkable degree. We have witnessed the growth of new fields of medicine, as well as the seemingly endless need for subspecialization. As individual practitioners in the wake of such amazing progress, we must come to grips with the fact that no single physician can meet all of the needs of our complex population. In our CanMEDS structure, we acknowledge the value of the Medical Expert as only a part of the whole: previously, this was regarded as the very foundation upon which our medical training was built.

As training has evolved, we have rediscovered the notion of “patient-centred care.” The values associated with non–Medical Expert roles have been championed. Society as a whole benefits from us working collaboratively, and constructively, toward this holistic approach.

This begs the question, “How do we incorporate these roles into our training programs?” We need to craft new learning objectives and find ways to assess individual competence in these domains. In the literature, there is clear recognition of the importance of role modelling as a crucial component of the educational process – especially when teaching professionalism, communication, and health advocacy.

In preparation for this article, I was pleased to see a large...
number of articles discussing this very topic. So many, in fact, that there are actually several systematic reviews! For the most part, these articles focus on characterizing what a role model is from the perspectives of both trainees and preceptors. In summary, preceptors who are thought of as positive role models have the following characteristics:

- Clinical competence
- Humanistic qualities with a patient-centred approach
- The ability to create a positive and safe learning environment
- Excellent interpersonal and communication skills
- Leadership skills
- Enthusiasm for their job

These attributes read like a résumé of someone I would certainly hire. Whether I had actively considered it at the time, they are also qualities embodied by colleagues who I have considered to be role models in my own training. Interestingly, it has been noted that a preceptor’s list of publications and awards are of little importance to trainees. Taking it a step further, trainees were also able to identify attributes of negative role models, including poor communication, unprofessional attitudes, disinterest, cynicism, and self-servitude. It is important to realize that, positively or negatively, role models can have a significant impact on the career choices of their trainees.

So where does this leave us? We know that trainees need good role models. We know that several groups of researchers have gone to great lengths to tell us that positive role models have specific qualities. We know that these role models can have great influence on the education and career trajectory of trainees. Yet, we haven’t learned how to harness these skills and incorporate them into a formal curriculum. Indeed, the literature states that most role modelling interactions occur outside the curricular setting. We need to encourage academia to recognize and formally incorporate high-quality role modelling into our training. Clinical teachers are, like it or not, role models. As such, educational programs may want to take steps to garner and hone excellence in role modelling.

While I believe that awareness is crucial, I’m not sure that formalizing how to be a role model is the answer. I think that doing this may run the risk of being at odds with the type of role modelling that trainees actually desire. The literature tells us what good role models might look like, but it doesn’t answer the question of why trainees need them in the first place. In my experience as a trainee and attending the IRLS, I was able to get a good idea of just what these reasons may be.

Trainees are in a perpetual state of transition. While attending to daily clinical responsibilities, all sights are focused on our respective certification examinations, making the Medical Expert role disproportionately important during training. Throughout this time, trainees are also trying to assemble an idea of what their future career will look like. Considerations include specializing, fellowships, location of training (community versus university), research, teaching, administration, and so on. We have access to abundant resources for clinical knowledge, but what we often lack is information, support, and guidance for career planning. Hence, we look to our preceptors to show us what independent practice can look like. We need advice on what avenues to pursue, how to develop a research or academic portfolio, how to negotiate for jobs, and more. The recent Royal College report about unemployed specialists underscores the need for improvement in this area.

So, yes, we all need role models to set examples for how to exhibit compassion, empathy, and professionalism and to communicate with our patients. We also need those role models to be aware that what they say and how they act can have a profound impact on us, whether intended or not. Our trainees (and patients) deserve for this example to be unbiased and positive in order to promote a culture of collaboration and health advocacy in our society. Beyond this, however, we also need our training programs to understand that their trainees need role modelling for pragmatic career-planning purposes. By strengthening this support, our trainees will have more confidence in their future opportunities and will be better positioned to practise their patient-centred craft as role models for the next generation.

References