16RC2

How to teach medical professionalism in anaesthesia

S.E. Curry

Department of Anesthesia, Columbia University, New York City, USA

Saturday, June 6, 2009 16:00 - 16:45 Room: White 1

With the rise of humanitarianism in the 19th century professionalism appeared in medicine. It became important to relieve suffering of patients, starting with Clara Barton and nursing on the battlefield. Since medicine couldn't actually do much to cure anyone, hand holding and empathy were the hallmarks of good professional care. With the development of antibiotics in the 20th century suddenly people could be cured. The definition of the 'good doctor' became the one who was the most scientific and the most up-to-date on the latest techniques and empathy went by the wayside. Doctors became gods on a pedestal who could cure anything and could do no wrong. However, when wrong occurred society felt cheated and, at least in the US, litigation became the way society fought back. But after a while the literature showed that doctors who had balanced science and empathy were less likely to be sued than those who were only smart and knowledgeable. Patients wanted both. Less obviously, but equally important in a specialty such as anaesthesiology, was the way doctors interacted with colleagues and other specialists. It appeared that in this area we did badly. We treat patients well (they won't pay us if we don't!). But we aren't so nice to each other. This creates an unpleasant work environment and has the potential to impact adversely on patient care and safety.

Definitions

One of the main problems with teaching and enforcing professionalism is the lack of a clear definition of professionalism. Lapses in professionalism are easier to point out, but they too are often vaguely defined. "I know it when I don't see it" or "It's when the other person is misbehaving" are often used to describe what is going on. Ethics and professionalism are intertwined and are often substituted for each other. But they are not the same thing. Ethics is a value system that most people learn at their mother's knee (everything I really need to know I learned in kindergarten). Professionalism is specific to the profession in question and is primarily a mantle of behaviours donned at the end of training and practiced and honed throughout one's professional career. Roberts in Academic Psychiatry [1] differentiated the two nicely. '*Ethics is an endeavor. It refers to ways of understanding what is good and right in human experience. It is about discernment, knowledge, self-reflection, and is sustained through seeking, clarifying, translating. It is the concrete expression of moral ideals in everyday life. Ethics is about meaning, and it is about action*. *The core of professionalism constitutes "…those attitudes and behaviors that serve to maintain patient interest above physician self-interest". Accordingly, professionalism…aspires to altruism, accountability, excellence, duty, service, honor, integrity, and respect for others'*.

Hilton and Slotnick suggest six domains for professionalism [2], which are divided into two categories. The first are personal (intrinsic) attributes of doctors and include ethical practice, reflection and self awareness, responsibility and accountability for actions (commitment to excellence/lifelong learning/critical thinking). The second are co-operative attributes of professionals and include respect for patients, teamwork and social responsibility.

Wagner et al showed that the concept of professionalism varies with who you ask [3]. Attending physicians differ from resident trainees, who differ from students, who differ from patients. Though the themes elucidated from all four groups were similar, the emphasis differed. For instance, attending physicians emphasised maturity and experience, dealing with stress and the power of resiliency. Residents emphasised being decisive and succinct in their actions. Students emphasised the patient-family relationship and the fear of hurting someone. Patients wanted to be recognised by name, wanted to be asked if they were comfortable and were concerned about the tone of voice with which they were addressed. Reed et al looked at the behaviours of highly professional first year residents [4]. In their study peer assessment emphasised good turnover and providing good cross coverage. Senior residents thought it was important for juniors to know their limitations. Medical students looked at the residents' commitment to medical student education and communication skills. Faculty looked for humanistic qualities in residents. Ancillary personnel wanted their concerns to be addressed and also looked at patient communication skills.

Surdyk et al analysed the literature and came up with five overlapping relationships they felt defined professionalism [5]. They included physician-to-patient, physician-to-society, physician-to-health care system, physician-to-physician, and physician-to-self relationships. This last theme is an interesting one in that it is a change from the past. It not only refers to things like not taking drugs, getting enough rest and studying, but also spending time with loved ones and having outside interests. The 'new generation' of physicians is insisting on time for these activities and we 'old timers' are having mixed feelings about it which is causing some friction.

In 2005 Kearney published a study which canvassed the Canadian anaesthesia Program Directors as to their views on what should be evaluated for professionalism in resident candidates [6].Through a series of three questionnaires Kearney and the group came up with 40 qualities which defined professionalism in anaesthesia. They were grouped into three themes: *humanistic* (integrity, maintains confidentiality, respect for patients' views, empathy); *personal development* (self-awareness, commitment to lifelong learning, copes with uncertainty, accepts criticism appropriately, maintains a balance between personal and professional lives); and *meta-competences* (vigilance, responsiveness, team worker, advocacy, communicativeness). The importance of these qualities is that they were agreed to by anaesthesiologists. Professionalism, by its nature, needs to be defined by specialty and there are differences. For instance, we deal with unconscious patients for the most part and this requires a different commitment than to the awake-office patient.

Teaching

It's fairly clear from the literature that professional behaviour is an important component of our everyday lives. How should we learn it or teach it? Role modeling has been the traditional method, but teaching professionalism needs to be explicit, not just implicit. There are numerous studies [8-10] about simulation, simulated patients, small focus groups, lectures, online courses, etc. that are used to teach professionalism. Yudkowsky et al developed standardized patient-based clinical scenarios which could be adapted by different specialties and used to train and establish competency of residents [8]. Residents have stated that it is more relevant to them to hear about true clinical scenarios than abstractions [1]. Srinivasan et al developed objective structured teaching evaluations (OSTEs) to help faculty learn to rate professional behaviour during scripted 'lapse' scenarios [9]. This enabled them to better teach and evaluate residents during situations where professional lapses were noted. Dorotta et al took the American Board of Internal Medicine's views on professionalism, adapted them to what they thought was appropriate for an anaesthesia residency program and created a teaching and evaluation program for their residency at the Cleveland Clinic [10]. The teaching was based on the level of training and ranged from humanistic lectures to first year residents to case based scenarios for graduating seniors. They also told residents before each rotation what the expectations were for them and what they were being evaluated on, including professionalism characteristics.

Unfortunately, lectures and workshops can't always counteract 'real life'. What good do they do if residents and students leave the classroom and witness condoned behaviour they've just been told is inappropriate. Hilton and Slotnick refer to professionalism as being an acquired state [2], as opposed to a trait. It is a state that takes years to attain and must be maintained throughout one's professional career. All too typically professionalism is a lecture or a workshop for residents given once a year and no-one shows up for it. Teaching needs to include faculty and staff so that the culture of an institution is altered as well. Residents and students rightly feel that they are being rated on professionalism in an unprofessional environment, meaning who is rating the attending physicians [7]. Many specialties have produced codes of conduct and professionalism treatises. These have come from the 'top' and are passed down to fellows, residents and ultimately students. The American Society of Anesthesiologists has a code of ethics. The Accreditation Council for Graduate Medical Education (ACGME) has laid out guidelines by which residents are to be rated (see Appendix). But since professionalism is part of our every day lives why not use every day to teach it. Each of us sees instances of good and bad professional behaviour that can be used to teach junior residents and medical students. Even without specifics we, as faculty, can make use of the day-to-day rich material we are offered in the ORs and ICU to teach. We need only open our eyes and ears and take advantage.

At Columbia we have third year medical students rotating through every few weeks. Though they have lectures about anaesthesia sprinkled throughout their week, they spend most of their time in the operating room watching and helping the team. We also ask them to document good and bad incidents they witness with respect to the professional behaviour of the anaesthesia, surgical and nursing staffs. These are anonymous, and the names of the 'actors' are not stated. We then discuss what they saw and go over why the incidents were 'bad' or 'good', why they would emulate the 'good' behaviours and how they would alter the 'bad' behaviours. From their observations it seems clear that at least in this one institution we treat patients quite well. We are not so kind to each other and other staff members. The beauty of this method is that it uses fresh real material, not theoretical cases. We have recently started using this method of teaching in resident education. The goal is not to change the behaviour seen, but to make sure the right message is taken from it. This way when students at all levels are faced with lapses in professional behaviour they can accept that lapses occur, have

tools to deal with the situations and hopefully won't behave that way themselves in the future. By validating their correct assumptions that the lapsed behaviour is inappropriate they won't be left with the feeling "well I know it's wrong, but Dr 'So-and-So' got away with it so I'll try it". By allowing them to 'vent' about some of the things they've seen and experienced they can maintain self-esteem and mature professionally. By discussing 'good' behaviour they know what to adapt for themselves.

Changing objectionable behaviour is a different problem altogether and is now being looked at by American accrediting organizations such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) as a patient safety issue. Interestingly, physician organisations are feeling threatened, stating that hospitals will use diffuse guidelines as a way of getting rid of outspoken staff members who don't tow the party line! That is a possibility, though a remote one. A smarter approach would be to work with hospitals to properly define inappropriate behaviour,, show a relation between it and threats to patient safety, and then offer programs to train and retrain faculty in real life scenarios to help with compliance. Carrots work better than sticks, though sometimes a stick is needed to get the attention of some people. By offering 'bonuses' for good behaviour you can probably get better compliance than threats. Threats, particularly financial ones, are the final tool for teaching and changing behaviour of faculty and they have to be administered fairly, with documentation and advanced warning.

Assessment

The final limb in teaching professionalism is assessment and can be both difficult and easy. Assessment is difficult if the ground rules are not well defined. Also, if the trainee feels the evaluators aren't fair in their assessments, they won't have any respect for the results. If the assessors are viewed as having many lapses in professionalism themselves anything they say will be discounted. Srinivasan's training of evaluators [9] is an excellent way to get around this problem. Greaves and Grant approached 'expert' clinicians and asked them how they assessed trainees [11]. Though this was not specifically for professionalism, the experts were able to come to consensus about what was important in all aspects of an anaesthesiologist's behaviour to achieve best outcome for the patient. Dorotta et al included assessment tools in their curriculum for professionalism which included case scenarios and true/false tests [10].

All in all trainees need to perceive that his/her assessment is fairly applied and that professionalism expectations are applied to faculty as well. It needs to be understood that on a day-to-day basis lapses will occur by them and by others. As long as they have tools to deal with these situations and have the opportunity for remediation, professionalism can be successfully taught, learned and incorporated into daily professional life.

In Table 1 is a suggested algorithm to follow. Some real life scenarios from our teaching experience are described below.

Table 1

Anaesthesia professionalism algorithm

A	- Altruism, the hallmark of professionalism
N	- Negotiate conflict resolution
E	- Education and the pursuit of excellence
S	- Safety of our patients and Sensitivity to their needs
T	- Truthfulness in all medical matters
H	- Humility and humanism keep arrogance away
E	- Ethical and moral behaviour - avoid doing wrong
S	- Self-care is vital, as is self-respect and respect for others
I	- Inquisitiveness and inquiry into the unknown
A	- Accountability for our actions and those of our peers. Autonomy requires standards

Real scenarios

One of your residents has been acting strangely lately, not around on call. You share a call room and one day you notice some empty syringes and an empty vial of sufentanil in the room. *What is your responsibility to this resident? (Self-care)*.

You're at a chiefs meeting in the hospital. You got there a little late because you were taking care of a patient. As you get into the meeting you hear the chief from medicine bad mouthing one of your residents about a difficult intubation at an arrest. *What is your response? (Conflict resolution)*

It's Friday night and you have the weekend off. You decide to go with your boyfriend to a local bar for some fun. There you spot one of your residents in a drinking contest. He is clearly already 'plastered'. You know this resident is on call on Saturday because you made out the schedule. *What is your responsibility here? (Self-care)*.

You're looking forward to the ASA annual meeting because it's in a city you like and you plan to do lots of sightseeing, etc. In fact, if you play your cards right, you may not go too much to the meeting at all. The new CME rules are annoying and you realise to get credit and tax breaks for the meeting you're going to have to attend something. But since it's an honour system, you figure you'll just send in some meeting time information, even to things you didn't attend. *Is this a problem? (Honesty)*

You are seeing a patient in the pre-op clinic scheduled for gynaecological surgery. The patient asks you your opinion of her surgeon. The surgeon happens to be a particularly poor one who doesn't do the scheduled procedure well at all. She won't kill the patient (you'll see to that), but the patient will probably undergo much unnecessary sick time afterwards. *What is your responsibility to the patient, and to the surgeon? (Service to patients)*

The surgeon you are working with is very good at what he does. But he is constantly belittling the staff, yelling at the nurses, and arguing with you about cancellation of cases. Recently a patient of his came to the OR woefully unprepared for surgery. You explain to the patient and family that you have to check over some details with the surgeon before you agree to start this case. Just as you are about to turn away to find him, here he is. He has heard the last part of your conversation and, in front of the patient, accuses you of delaying tactics and putting the patient's life at risk. You try to pull him aside to discuss the matter privately, but to no avail. He turns to the patient and asks if they want their surgery and who is their doctor anyway? The surgeon or the anaesthesiologist? *How do you handle this? (Service to patients, respect for colleagues)*

A popular attending physician, prominent in the department, is very fond of telling 'rude' jokes in the OR. He is particularly degrading to women and minorities in his jokes, though they are usually quite funny. You've laughed at them yourself. There is a pregnant medical student in the OR on rotation one day and he takes a fancy to her, patting her belly and complimenting her on how lovely she looks. She seems offended by his attentions, but is unsure of how to handle the situation. The attending is her preceptor for the rotation and is responsible for her grade. *What is your responsibility? (Accountability)*

You're on a new rotation and just completed a difficult case that was made more of a problem because you hadn't read about it ahead of time. Your attending dressed you down for this and you swore to yourself that you'd never do that again. You went home to prepare for your next difficult case. A friend has left a message that she has tickets for that night to a concert of your favorite rock artist. *What do you do? (Pursuit of excellence, inquisitiveness)*

Appendix

ACGME guidelines for rating residents:

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Residents are expected to:

- demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development;
- demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices;
- and demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

References

1. Roberts L, Hammond K, Geppert C, Warner T. The positive role professionalism and ethics training in medical education: a comparison of medical student and resident perspectives. Academic Psychiatry 2004; 28: 170-82.
2. Hilton S, Slotnick H. Proto-professionalism: how professionalisation occurs across the continuum of medical education. Medical Education 2005; 39: 58-65.
3. Wagner P, Hendrich J, Mosley G, Hudson V. Defining medical professionalism: a qualitative study. Medical Education 2007; 41: 288-294.
4. Reed DA, West CP, Mueller PS, et al. Behaviors of highly professional residents. Journal of the American Medical Association 2008; 300:1326-33.
5. Surdyk PM. Lynch DC, Leach DC. Professionalism: identifying current themes. Current Opinion in Anaesthesiology 2003; 16: 597-602.
6. Kearney R. Defining professionalism in anaesthesiology. Medical Education 2005; 39: 769-76.
7. Ephgrave L, Stansfield RB, Woodhead J, et al. The resident view of professionalism behavior frequency in outstanding and “not outstanding” faculty. American Journal of Surgery 2006; 191: 701-5.
8. Yudowsky R, Downing SM, Sandlow LJ. Developing an Institution-based assessment of resident communication and interpersonal skills. Academic Medicine 2006; 81: 1115-22.
9. Srinivasan M, Litzelman D, Seshadri R, et al. Developing an OSTE to address lapses in learners’ professional behavior and an instrument to code educators’ responses. Academic Medicine 2004; 79: 888-96.
10. Dorotta I, Staszak J, Tetzlaff JE. Teaching and evaluating professionalism for anesthesiology residents. Journal of Clinical Anesthesia 2006; 18: 48-60.
11. Greaves JD, Grant J. Watching anaesthetists work: using the professional judgement of consultants to assess the developing clinical competence of trainees. British Journal of Anaesthesia 2000; 84: 525-33.